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WOMEN AND THEIR CHILDREN: PREVENTION FOR A HEALTHY GEORGIA

HEARING

BEFORE A

SUBCOMMITTEE OF THE

COMMITTEE ON APPROPRIATIONS

UNITED STATES SENATE

ONE HUNDRED SECOND CONGRESS

FIRST SESSION

SPECIAL HEARING

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CONTENTS

	Page
Opening remarks of Senator Fowler	1
Prepared statement	2
Statement of Representative Ben Jones	3
Statement of Dr. William L. Roper, Director, Centers for Disease Control, Department of Health and Human Services	5
Prepared statement	7
Prevention as a cost-saving concept	10
Statement of Ginger Floyd, director of the Family Health Services, Georgia Division of Public Health	13
Statement of Barbara Chamness, executive director, Childkind, Inc	26
Prepared statement	28
Statement of Dr. Paul Wiesner, director, DeKalb County Board of Health	29
Prepared statement	33
Statement of Davis Cooper, Jr., principal, Tilson Elementary School, Decatur, GA	50
Prepared statement	52
Statement of Dr. Stephen Thacker, Director, CDC's Epidemiology Program Office	53
Prepared statement	56
Comprehensive school health education program	60
Statement of Dr. Elizabeth Connell, professor of gynecology and obstetrics, Emory School of Medicine	68
Prepared statement	69
Statement of Erminia McIntyre, instructor, Pace Academy, Atlanta, GA	70
Prepared statement	72
Cancer increase	74
Statement of William White, coordinator, human services facilities, DeKalb County, GA	75
Prepared statement	77
Program modification	79
Statement of Dr. Gloria Clayton, professor of nursing, Medical College of Georgia	80
Prepared statement	84
Problems of older American women	87
Statement of Virginia Bales, Deputy Director, CDC Center for Chronic Disease Prevention and Health Promotion	89
Prepared statement	91
Inaccurate screening tests	94
Prepared statement of Senator Wyche Fowler, Jr	98
Statement of Foundation of Wesley Homes, Atlanta, GA	101
Statement of Planned Parenthood of the Atlanta Area, Atlanta, GA	102
Letter from Dr. Jean Rawlings Sumner	103
Statement of Dr. Marilynn R. Winston, Atlanta area chapter, Alzheimer's Association	104

WOMEN AND THEIR CHILDREN: PREVENTION FOR A HEALTHY GEORGIA

MONDAY, MAY 20, 1991

U.S. SENATE,
SUBCOMMITTEE ON LABOR, HEALTH AND HUMAN
SERVICES, AND EDUCATION, AND RELATED AGENCIES,
COMMITTEE ON APPROPRIATIONS,
Atlanta, GA.

The subcommittee met at 8:30 a.m., in auditorium B, Centers for Disease Control, Atlanta, GA, Hon. Wyche Fowler, Jr., presiding.

Present: Senator Fowler.

Also present: Representative Ben Jones.

NONDEPARTMENTAL WITNESSES

STATEMENT OF DR. WILLIAM L. ROPER, DIRECTOR, CENTERS FOR DISEASE CONTROL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

OPENING REMARKS OF SENATOR FOWLER

Senator FOWLER. Good morning, everybody. You are certainly more orderly than the raucous crowds that greet us in Washington.

Before I begin, I want to thank the extraordinary architects and planners and construction staff here who made this look like a Senate chamber. I am sure C-SPAN will be very impressed. I have never been this high up on the hierarchy before. I sort of like it. I may continue to take this set with me wherever I go. [Laughter.]

This is a hearing of the Senate Appropriations subcommittee, the Subcommittee on Labor, Health and Human Services, and Education.

I do want to thank the chairman of the full committee, Senator Byrd of West Virginia, and Senator Harkin from Iowa who is the chairman of the subcommittee. Both those men are supporters of our public health system, and of the Centers for Disease Control in particular.

All Americans should be concerned about a vast array of growing public health problems. As all of you know, the CDC as our Nation's lead prevention agency can play and must play a major role in addressing these problems.

I am grateful that the facilities of the CDC could be made available today for our hearing on prevention opportunities for the health of women and children.

As a nation, we devote 12 percent of our gross national product to our health care system. The cost of Medicare was $14 billion in 1975; will soar to close to $100 billion this year.

In spite of this massive spending, we still see hospitals and physicians disappearing from many rural areas, an infant mortality rate that ranks an unacceptable 22d in the world, and over 37 million Americans with no insurance protection. That is when there are no layoffs. When we have layoffs in the middle of a recession that 37 million doubles with no health insurance in this time of prohibitive health costs.

Compare this record with what has been accomplished through disease prevention efforts. In 1977, the age-old killer going back to Biblical days, smallpox, was literally eradicated from the face of the Earth.

Early detection and prevention of tuberculosis have brought us a long way from the days when there were sanitoriums all over the countryside.

In these and so many other cases that I will not take time to mention, prevention can relieve unnecessary suffering, reduce loss of life, and go on to improve our productivity and general well-being.

In 1991, an estimated 175,000 women will be diagnosed with breast cancer, and another 132,000 with cervical cancer. Together, these diseases will kill close to one-half million women, while the means are here now to prevent many of these deaths. It is technically feasible right now to establish a national comprehensive program to ensure that all women in the United States will benefit from screening and early detection.

I do not want to take any more time. I will put my full statement in the record. I simply want to end by saying I am proud that the Nation's primary preventive health care agency, the Centers for Disease Control, is based here in Georgia. Since 1946, you have played a critical role in America's complex public health system, and today we are going to explore the scope of some of the most pressing problems facing women and children, and the opportunities for prevention and early intervention.

PREPARED STATEMENT

I believe from my own research and knowledge that we have the means right here if we will learn to better employ them. As one charged with the responsibility of appropriating our limited Federal resources, I am certainly committed to learning how we can best support the CDC and thereby invest in the future health of our country.

[The statement follows:]

STATEMENT OF SENATOR WYCHE FOWLER, JR.

The Subcommittee will come to order. This is a hearing of the Senate Appropriations Committee, Subcommittee on Labor, Health and Human Services, and Education. I want to thank Senator Robert Byrd, chairman of the Committee, and Senator Tom Harkin, chairman of the Subcommittee, for their support for this initiative. They are both friends of our public health system, and of the Centers for Disease Control in particular.

All Americans are concerned about a vast array of growing public health problems. The CDC, as our nation's lead prevention agency, can play, and must play, a major role in addressing many of these problems. I am pleased the facilities of CDC could be made available today for our hearing on prevention opportunities for the health of women and children.

As a nation, we devote 12 percent of our gross national product to our health care system. The cost of Medicare, $14 billion in 1975, will soar close to $100 billion this year. In spite of that massive spending, we still see hospitals and physicians disappearing from many rural areas, an infant mortality rate that ranks an unacceptable 22nd in the world, and 37 million Americans with no insurance protection in this time of prohibitive health care costs.

Compare this record with what has been accomplished through disease prevention efforts. In 1977, an age-old killer, smallpox, was eradicated from the face of the earth. Early detection and prevention of tuberculosis have brought us a long way from the days when sanitoriums filled the countryside. In these and so many other cases, prevention can relieve unnecessary suffering, reduce loss of life, and go on to improve our productivity and general well-being.

Prevention measures can have their greatest impact on the health of mothers and children. This forms, without any doubt, the long term foundation for a healthy society. But we are nowhere close to reaching our potential in preventing health problems among women and infants.

In 1991, an estimated 175,000 women will be diagnosed with breast cancer and another 132,000 with cervical cancer. Together, these diseases will kill more than half a million women in this decade even though the means exist through early intervention to prevent almost all cervical cancer deaths and a third of those from breast cancer. It is technically feasible right now to establish a national comprehensive program to ensure that all women in the United States benefit from screening and early detection.

Smoking during pregnancy is also a serious health problem, but one that requires no breakthroughs in medical technology. It only requires education, and a change in behavior.

Still, over 900,000 newborns in the United States—one out of every four—is exposed to these health risks because of maternal smoking. This is a stark example where simple prevention would save untold money, lives and suffering.

I won't begin to place a monetary value on human life, but common sense will tell us that preventive measures can go a long way to alleviate the financial burden of health care in this country today—a burden that many families simply cannot support—a burden, I fear, our economy cannot continue to bear in the long run.

I am proud that the nation's primary preventive health care agency, the Centers for Disease Control, is based right here in Georgia. Since 1946, CDC has played a critical role in America's complex public health system. Today we are going to explore the scope of some of the most pressing health problems facing women and children, and the opportunities for prevention and early intervention. I think we have the means right here, if we will learn to better employ them.

As one charged with the responsibility of appropriating our limited federal resources, I am committed to learning how we can best support CDC and thereby invest in the future health of this nation.

STATEMENT OF REPRESENTATIVE BEN JONES

Senator FOWLER. I am extremely pleased to welcome this morning my colleague in the Congress, Fourth District Congressman Ben Jones, who will make opening remarks, and then following that we will hear from CDC's Director, Dr. Bill Roper.

Suffice it to say in manner of introduction that Ben Jones is one of our best, both in diligence and knowledge, and in my experience with him, always putting the public interest ahead of private interest.

Glad to have you, Congressman Jones.

Mr. JONES. Thank you, Mr. Chairman.

My purpose here today is to welcome you, Mr. Chairman, welcome this subcommittee, and to welcome the work of this Appropriations Committee, and to welcome you not only to the Fourth District of Georgia, but to the great Clifton Corridor, and to welcome everyone else here, too.

We have a problem in this country that is not going to go away, which is an elephant in the room. It is not talked about much, you do not see it on the front page, but it is something that must be addressed and will be addressed, I think, more and more in the next decades.

As Senator Fowler pointed out, we have a health care crisis in this country. As Americans are living longer and longer, as health care costs are rising, as insurance costs are rising, we have come to a critical point, and we have almost 40 million uninsured Americans, so in the next few years we will be investigating and also trying to come up with ideas as to how to address this crisis. In this Congress, there will be a lot of ideas run up the flag pole to see if anybody salutes. Something must be done.

The United States ranks near the top in advanced industrialized nations in the number of our infant mortalities. This is a tragic statistic, but it is true, and the State of Georgia in the United States ranks behind only Mississippi, South Carolina, and the District of Columbia in the number of our infant deaths, something we have got to turn around, and here within a few blocks we have the CDC, we have the great Emory University, we have Egleston Children's Hospital, we have the Atlanta area's Veterans Administration medical center, we have the American Cancer Society.

If the answers are going to be found to these dilemmas, I think the answers are going to be found here. It will spring from the talents of the people who live and work right here.

We are fortunate to have here the Nation's prevention agency, the CDC. From its humble beginnings during World War II as an agency which was assigned to malaria control in war areas, into the 1970's when its assignment was greatly enhanced, to become a prevention agency it has done tremendous work, and we are proud of the association and proud that they are here, and particularly proud of the work the CDC has done in education and in prevention of communicable diseases among young people through its immunization programs not only in the United States but its work worldwide. I welcome you here today, and I am sure that there will be very valuable information that comes from this.

Senator Fowler pointed out that we live in a time of enormous deficits. In the last 10 years, we have managed somehow or another to more than triple our national debt, so money is tight, but it seems to me that in times like that that is when we dig down and consider what our priorities are, where do we really want to spend our money, and if we as a nation are not prioritizing spending money on our children, that most important investment that any society can make, then we will be making a terrible statement about ourselves I think. This is something that we should do, something that we can do, and I think something that we must do.

I want to thank you, Senator, for coming here. I have another meeting that I must go to, and then I am flying back to Washington this morning, but I guarantee you that you have my full support in your efforts, and thank you for coming here, thank you for having these hearings.

Senator **Fowler**. Ben, thank you very much.

In fact, what he is doing is chairing a hearing himself on Federal research efforts at Emory starting in a few minutes, so, Ben, thank you very much for taking your time to come and welcome me to my own district. [Laughter and applause.]

STATEMENT OF DR. WILLIAM ROPER

Senator **Fowler**. Next we will hear from CDC Director, Dr. Bill Roper, who has been in charge since 1990.

Dr. Roper, I want to personally thank you for your extraordinary commitment to prevention, and thank you for your hospitality. We are delighted to be here and let you set the stage for us.

Dr. **Roper**. Thank you, Senator.

I would say to both you and the Congressman, welcome to CDC. It is a wonderful day for us to have you both here, and especially for you to be holding this hearing here.

CDC has put on what we think is our best show for you, and we hope this indicates to you how delighted we are for you to be here and to be focusing the Nation's attention on CDC and through us on prevention.

The people who are going to be speaking to you later this morning are experts, some from CDC, others from the Georgia community, and I think the picture that they are going to be painting is one of problems, but also of opportunities. These are opportunities that will be fulfilled provided we have the resources to undertake the programs and activities that we need to.

We understand the fiscal realities facing our Nation. We just believe that we can make a better case than the next person as to why our programs deserve to be funded.

CDC is the Nation's prevention agency, and as both you and the Congressman have said, what we are doing today is highlighting prevention. CDC is an organization that has been here for decades. We are a Federal agency, but just as surely we are a Georgia institution, and it is in that spirit that again we are delighted for your presence.

I would also welcome you on behalf of another Federal agency based here that I also head called the Agency for Toxic Substances and Disease Registry [ATSDR]. I will say more about it in a bit, but these two organizations work very carefully and closely together, particularly on environmental health matters.

The people who are going to be speaking later this morning will be talking about Georgia health problems, but I think it is fair to say that Georgia is not unique in the problems and opportunities that we face. They will be painting a picture that surely is applicable for the rest of the country.

We will be talking about CDC's unique expertise, and we really do believe we are a unique agency. We deal with public health problems using the techniques of epidemiology, laboratory and behavioral sciences, and data collection and analysis, and whether it is a problem of AIDS or another infectious disease, or violence, or smoking and health, the techniques that we bring to bear to deal with these problems are applicable across the board. Disease control and prevention are closely linked here at CDC.

I am a pediatrician, and am delighted, therefore, that you are focusing attention in this hearing on women and children. One of our major priorities here at CDC is improving the health of the Nation's children, and we have got a series of programs and initiatives geared to do just that: Smoking cessation in pregnancy, childhood immunization efforts, programs to address the problems of infectious disease and injuries in child care settings, our initiative to prevent lead poisoning in children, and a variety of others.

Women's health issues are pressing problems for the Nation and they are important issues for us here at CDC. You will be hearing about a number of these, including sexually transmitted diseases, AIDS and HIV infection, prenatal care, counseling to prevent smoking and consumption of alcohol during pregnancy, and immunization to prevent hepatitis B infection from being passed on to children.

We think that one of the most important things we can do is teach children to develop safe and healthy habits, prevention habits as young children that will grow to last a lifetime. Comprehensive school health education, therefore, is fundamental for our plans for the future.

We do not have time this morning to talk about all of the programs and activities that we are engaged in, but I will just note a few others beyond the specific issues on the agenda; for example, protecting the safety and health of people at the workplace, and preventing disease and death from environmental hazards.

As you have said, prevention is the mission of CDC. It is a concept whose time has come. Prevention is an idea that has been the subject of many good speeches over the years, but I think we are making the transition now from a time of just giving good speeches to making prevention happen.

Last fall Secretary Sullivan released the new "National Health Objectives for the Year 2000" called Healthy People 2000. Shortly, we will be publishing another companion publication called Healthy Communities 2000 that will be a guide to help States and communities develop their own objectives and contribute to the national goals.

We are here to talk about appropriations, and prevention, and CDC. I am just delighted to point out to you that for the first time ever the President's budget for next year, fiscal 1992, has an entire chapter devoted to prevention. President Bush has requested the largest budgetary increase in CDC's history for prevention programs other than AIDS, and he has requested increased funding for immunization, infant mortality prevention, breast and cervical cancer prevention, smoking cessation, injury prevention, prevention of lead poisoning—all of these are issue areas for which CDC has responsibility.

Senator FOWLER. How much is the increase that he has requested?

Dr. ROPER. The total increase is $125 million for next year.

Senator FOWLER. And do you happen to know what percentage increase that is over the present allocation?

Dr. ROPER. That is on a base of $1.3 billion, so it is almost a 10-percent increase.

Your presence here today attests to the importance of prevention not only to you but to your colleagues in the Congress. Prevention is an idea that is widespread in its popularity. It not only makes sense, but it makes good dollars and cents because prevention practiced today avoids the need for health care expenditures in the future.

As we talk about reforming our out-of-control health care system, my plea to you, as it was recently in a hearing before Chairman Rostenkowski and the Ways and Means Committee, is to make prevention a key part of whatever national health system we structure for the future.

We are asking our health care system to do much today, and the expenditures that we are putting out are more than any other country in the world. I just believe that the proven techniques of prevention should be capitalized upon as we reform health care.

For example, we know that childhood immunization works. We have documentation of the tenfold return from measles, rubella, and polio immunization. We also know that smoking cessation programs for pregnant women work—that is, teaching women not to smoke while they are pregnant will ensure that a number of them will quit smoking and their babies will be more healthy because of it. We know, for example, that 10 percent of the cases of infant mortality are due to smoking during pregnancy.

Prenatal care itself is cost-effective. Efforts to prevent the complications of diabetes and many other chronic diseases do work.

Finally, health promotion programs work. We know that private employers who have chosen to spend money up front to make their workplaces safer and to help their workers to be healthier benefit from fewer health expenditures down the line.

I have highlighted only a few of the programs we know work and that provide rich dividends for the dollars invested, but I would finally just make the point that money is not the bottom line. We are here to talk about prevention because it makes people healthier; the quality of life that they enjoy is much greater because of the practice of prevention.

I said a few words at the outset about ATSDR, the Agency for Toxic Substances and Disease Registry. I would also note that ATSDR is the principal agency in the Federal Government charged with carrying out the public health mandates under the Superfund statute, and the other subcommittee you sit on in the Appropriations Committee deals with EPA's budget and ATSDR's budget. We are appreciative of your support for those activities.

PREPARED STATEMENT

In closing, let me reiterate my belief that an investment in prevention is an investment in the future both in dollars and in quality of life. It is our wisest health care investment.

We sincerely appreciate your interest in CDC, and are delighted you are here today.

I would be happy to answer your questions.

[The statement follows:]

STATEMENT OF DR. WILLIAM L. ROPER

Senator Fowler, on behalf of all our employees, I welcome you to the Centers for Disease Control (CDC), the Nation's prevention agency. Your presence here today indicates the importance you place on the health of our citizens and on prevention as a means to ensure the public's health. Your interest in CDC's activities is encouraging to all of us who are working to make prevention a practical reality both here in Georgia and throughout this country. We are pleased that you and CDC share a common view of the excitement and importance of this challenging enterprise.

I also welcome you on behalf of the Agency for Toxic Substances and Disease Registry (ATSDR), a second agency of the Public Health Service based here in Atlanta. As Director of CDC, I serve also as the Administrator of ATSDR. The prevention and public health mission of ATSDR is closely linked with that of CDC, especially since CDC has two organizations with environmental programs: the Center for Environmental Health and Injury Control and the National Institute for Occupational Safety and Health. I will mention more about ATSDR later in my comments.

Senator, I am pleased to participate today in this hearing on prevention challenges in Georgia, the home of CDC. We will hear Georgians who are expert in their various fields talk about health problems faced by citizens of this great state. However, the testimony that we hear today does not apply only to Georgia. In this instance, Georgia is a microcosm of this country and of the health challenges faced by all Americans. Information that you take back to the Capitol with you can be used to help not only Georgians, but all of our citizens.

We will not have time at today's hearing to discuss all the important public health programs that CDC spearheads. Therefore, I want to point out that all of CDC's successes in public health depend on our unique expertise in epidemiology, laboratory and behavioral sciences, and data collection and analysis. By working with our partners in state and local health departments, and our colleagues in other countries, CDC's epidemiologists and laboratory scientists are able to help investigate and control outbreaks of disease, injury, and disability that crop up unexpectedly throughout this Nation and throughout the world. Disease control and prevention are closely linked at CDC.

As a pediatrician, I find it gratifying that your focus in this hearing is on women and children. One of CDC's major priorities is to improve the health of the Nation's children. We currently have a number of programs and initiatives geared to do just that: our prenatal smoking cessation program, our childhood immunization efforts, our programs to address the problems of infectious disease and injuries in child care settings, and our initiative to prevent lead poisoning in children, to name a few.

Women's health issues are often inseparable from those of their children, because what happens during pregnancy affects a child throughout life, either for better or for worse. You will be hearing today about some of the areas in which a woman's health and behaviors during pregnancy are integrally related to the health of her child. These areas include sexually transmitted diseases, such as AIDS/HIV infection and syphilis; prenatal care and counseling to prevent smoking and consumption of alcohol during pregnancy; and immunization to prevent hepatitis B infection.

As children grow, there are further opportunities for helping them to remain safe and well and to develop healthy habits that will last a lifetime. CDC seeks to capitalize on these opportunities. For example, CDC is a leader in childhood immunization, injury prevention measures, and comprehensive health education in our schools.

CDC has a wealth of programs to prevent disease, disability, and death among adults. These range from adult immunizations for influenza, pneumococcal pneumonia, and hepatitis B to activities to prevent sexually transmitted diseases, including AIDS/HIV infection; to breast and cervical cancer screening and health promotion activities targeting such areas as physical activity, good nutrition, and use of seatbelts and safety helmets. We also have excellent programs to protect the safety and health of people at the workplace and to prevent disease and death from environmental hazards. We pay particular attention to the health of women because they face increased risks from tobacco use, sexually transmitted diseases and AIDS, and, of course, such problems as breast and cervical cancer.

Prevention is the mission of CDC, and prevention is a concept whose time has come. In the past several months, the convergence of a number of events has thrust prevention to the forefront of public health policymaking. First, in September the Public Health Service released the new national health objectives for this decade, "Healthy People 2000: National Health Promotion and Disease Prevention Objectives." This important document, which contains almost 300 health objectives in 22 priority areas, will serve as a road map to direct the country's prevention agenda for the next decade. Later this year, a companion publication, "Healthy Communities 2000," will be available as a guide to help states and communities develop their own objectives and contribute to the national goals.

Next, for the first time ever, the President's proposed budget has devoted an entire chapter to prevention programs throughout Federal government. But even more important, President Bush has requested the largest budgetary increase in CDC's history for prevention programs other than AIDS. This is especially exciting in these times of limited resources and fiscal restraint. He has requested increased funding for immunization, infant mortality prevention, breast and cervical cancer prevention, physical fitness and healthy diets, smoking cessation, injury prevention, family planning, and prevention of lead poisoning—all areas for which CDC has responsibility.

Finally, your presence here today attests to the importance of prevention not only to you but to your colleagues in Congress. Your Committee has been extremely supportive of CDC's prevention efforts, and we are grateful for that support. I believe that prevention is being recognized by you and other Members, because it makes sense, not only in improved health and quality of life for our citizens, but also in fiscal terms.

Prevention will be an essential element in any successful effort to bring our burgeoning national health care expenditures into check. In 1990, health care expenditures in the United States totaled $647.3 billion, up from $604.1 billion in 1989 and $540 billion in 1988. This represents an average expenditure of $2,603 for every man, woman, and child in this country—more than any other country on earth. Approximately 97 percent of health care expenditures in this country go for medical treatment. And yet, statistics show that the United States ranks lower in basic measures of health than many other countries.

Clearly, we are asking our health care system to do more and more. Yet, despite huge expenditures, many adverse health conditions and deaths that are preventable have not been conquered. Prevention effectiveness research shows that prevention works and that an investment in prevention is an investment in the future. Let ne illustrate:

Our research has documented that childhood immunization works. The Nation has made great strides in reducing the number of cases of preventable childhood diseases and their consequences in this half of the century. We have effective vaccines that, if given appropriately, can prevent these diseases, and these vaccines are cost effective. For every million children vaccinated, medical care costs can be reduced by $9.8 million for rubella, $4.6 million for measles, $1.1 million for pertussis, and $200,000 for polio. The benefit-cost ratios for these vaccines are impressive, ranging from 2.6 to 1 for pertussis, to 10 to 1 for polio and measles, to 23 to 1 for rubella.

Smoking cessation during pregnancy works. We know that women who smoke during pregnancy are at higher risk of having a low-birthweight infant than are nonsmokers. Cost savings would result from a reduction in the incidence of low birth weight among infants and the attendant health complications. CDC studies show that, if one assumes that a smoking cessation program costs approximately $30 per participant and that 15 percent of pregnant women stop smoking, $3 in neonatal intensive care costs would be saved for every dollar spent on this program. In addition, prenatal care itself is cost-effective. According to the Institute of Medicine, for every dollar spent in this country on prenatal care for high-risk socioeconomic groups, $3.38 would be saved in medical costs for low-birthweight infants.

Efforts to prevent the complications of diabetes work. We know that diabetic women have a greater chance of incurring medical expenses both for themselves and for their babies than do nondiabetic women. Stabilizing the insulin levels of women before they become pregnant can help them assure a safe subsequent pregnancy and delivery. Thus, for every dollar spent for preconception care for diabetic women planning to become pregnant, $1.86 would be saved in medical care costs for the adverse effects of diabetes on the mother and unborn child.

Health promotion programs work. Studies have shown that worksite health promotion efforts can effectively promote healthy behaviors and help improve the health of U.S. workers. For example, the Live for Life Program, provided by Johnson & Johnson for its employees, resulted in lower in-patient hospital costs for participants than for employees who did not take part in the program. Workplace health promotion programs focusing on exercise, weight loss, smoking cessation, and hypertension and hypercholesterolemia control have been successfully implemented. Such programs have been shown to reduce absenteeism and to be cost effective, resulting in a savings of $2 for every dollar invested in the program.

Senator, I have highlighted only several of the programs that we know work and provide good dividends on the dollars invested. But we both recognize that where our citizens' health and lives are concerned, money is not the bottom line. These prevention programs would be worthwhile regardless of cost because they preempt the suffering and death of people. In reality, we place the greatest value on enhancing the quality of life.

Let me just say a word about ATSDR at this point. This agency was created by Congress to carry out the principal public health mandates under the Superfund statute. I am very proud of the job that ATSDR does under extraordinarily difficult conditions. For example, in conducting health assessments, our staff members work

very closely with citizens' groups concerned about their health as a consequence of proximity to Superfund sites. Too often the questions they are asking are difficult to answer given the current inadequacies in toxicological and environmental data. ATSDR is working diligently to improve our knowledge about the effects on public health of hazardous substances in the environment and prevent such adverse effects. As Administrator, I am most appreciative of the support you have provided to ATSDR through your efforts on the Senate Appropriations Subcommittee for HUD, VA, and Independent Agencies, including EPA, which provides funds for ATSDR.

In conclusion, I want to reiterate my belief that an investment in prevention is an investment in the future, both in terms of money and quality of life. In fact, I believe it to be our wisest health care investment.

Senator Fowler, we sincerely appreciate your interest in CDC and our national prevention programs. We are grateful for your leadership in the area of prevention and for the attention that your presence here today will focus on the health problems, not only of Georgians but of all Americans. I will be happy to answer any questions that you may have.

PREVENTION AS A COST-SAVING CONCEPT

Senator FOWLER. Thank you, Dr. Roper.

Dr. Roper, why is it that prevention has been so difficult to sell as a cost-saving concept? It's an approach that obviously, as you have just testified, not only is the best way to achieve the goals, the health goals that we want, lifestyle, long life, good habits, but it also lets you save money at the back end if you spend a little money at the front end. In your opinion why is it so difficult to communicate and enact into law?

Dr. ROPER. There are several factors, but I would say there are two major ones: first, the long period of time involved in implementation and then seeing results from prevention, and second, the different standards that we apply to funding programs that provide health care services compared with those for prevention services.

Let me just elaborate a minute. What I mean by the long period of time, is that it is very difficult to get someone to defer doing something today that is probably pleasant, like eating another course at dinner, or several desserts, or engaging in a number of unhealthful activities. It is hard to get them not to do that today on the belief that 20 years from now they will be healthier, or they will not have cancer or whatever.

We live in a short-term-oriented society. You have probably seen the T-shirts that say, "Life is uncertain, eat dessert first," and that is the way we tend to live. That is also the way we often operate Government programs—focusing on the immediate instead of the long term.

The second point I mentioned is about different standards. I used to run the Medicare Program, and all that is necessary for Medicare to begin paying for a new service is that it be shown to be safe and effective. It does not need to be cost-effective, but simply effective in relieving the condition that it is supposed to deal with. But in prevention programs we are typically held to a much higher standard that says we have got to present mounds of data that demonstrate to you and others that it is cost-effective to immunize, or stop smoking or whatever.

I am realistic and understand that that is the way it is going to be, and, therefore, one of the major things that we are engaged in here at CDC is a program of effectiveness research in prevention, building this mound of data so that we can convince the world, including those who provide our funding, that prevention does work. I am confident, as I said in my testimony, that we are coming around to this view as a society, that we want to be healthy and that we want to practice prevention. It is not just a trendy idea. I think it is a major societal change.

Senator FOWLER. Like you, Dr. Roper, I am very pleased at the President's—as you described it—his chapter on prevention and his outline, and also pleased that for the first time there is a recommended increase of that 10 percent.

That will not reverse what I understand is approximately a 13-percent decline since 1985 in funding programs other than AIDS for the combined agencies. If you were to receive from the Congress funding above the President's request, what would be your priorities and where would you want to use that money and direct that attention?

Dr. ROPER. If we are so fortunate—and thank you for your question—what we would be trying to do is invest that money wisely in the future consistent with everything I have said, and probably what that would mean is a sizable portion of it devoted toward strengthening CDC as an organization, as an institution, so that we can deal with unexpected challenges that come down the pike.

We have done a splendid job over the last decade focusing on particular problems, particular diseases, and issues. What we have not done so well on is building our infrastructure, as we call it, just as you, I am sure, deal with appropriations for roads and bridges and pipeline infrastructure. That same infrastructure in laboratories and people and buildings and whatever needs some strengthening here, and that is where we would probably put the bulk of the money.

Senator FOWLER. I do not think I can let you go without asking you at least one question on your diagnosis, if that is the appropriate word in medical terms, of the gap between the billions of dollars we spend on research and what we spend on prevention.

I have not looked this morning at the National Institutes of Health Budget, but I am sure it is something like $8 billion, and there are those of us who are concerned how much of that $8 billion of research actually ends up being translated into the public health system of the country, and specifically the prevention efforts, which I agree with you would save billions over the long term if we had that emphasis.

How do you describe or diagnose, whichever you are more comfortable with in your professional judgment, this gap between prevention and research, and is it growing or diminishing?

Dr. ROPER. I think our colleagues at NIH are doing a wonderful job of painting a picture for the country of the fruits of biomedical research, and the NIH budget is healthy. I am sure they would rather have more money as well, but they are doing quite well, thank you very much. [Laughter.]

We are not doing as well as we should be in translating the fruits of that research into practical programs, and I would not fault the Congress for that. I think much of that responsibility must fall on those of us, like myself, who have worked in State and local health departments and in the Federal agencies. We have not done as good a job as we ought to in painting a similar picture for the public as to the fruits of prevention programs.

The people who are the principal recipients of NIH funding are researchers in academic settings. I see some of my friends from Emory here, and they and many others around the country get NIH grants, and, therefore, they are in touch with you about the importance of the NIH budget.

In a similar kind of way we are trying to make sure that the people who are recipients of prevention programs, whether they are our budget dollars or somebody else's, understand that they are going to have to speak up, State and local agencies and others, so that the public at large, and especially the Congress hears from them just as well so that prevention enjoys its opportunities when the Federal budget is parceled out.

We understand the tight nature of the Federal budget, and the point I made jokingly at the outset I will make in a serious fashion now; that is, we are happy to go toe-to-toe with other Federal agencies and say our programs are just as good, we think better than yours, and we believe if we are articulate enough and are leaders enough then we will be able to reap the benefits when the Congress gets around to parceling out the money.

Senator FOWLER. Well, Dr. Roper, I thank you for your testimony, for your public service, and most of all for your efforts in prevention and your emphasis on the health of children.

Dr. ROPER. Thank you, sir.

Senator FOWLER. I thank you again for——

Dr. ROPER. I hope to sit down here and watch.

Senator FOWLER. Good.

Dr. ROPER. Have a good day.

Senator FOWLER. Thank you, Dr. Roper.

This high tech, I hope this thing gets the Braves. [Laughter.]

The first time I have ever had to watch an instant reply of my own eyebrows. [Laughter.]

For those of you on the back row, we have got plenty of seats down here up front. I know some of you will have to be in and out, but do not worry about that, come and sit down, and when you have to leave, do. We have got plenty of seats down front, and maybe there are some people in the hall.

What we are going to do this morning is hear from two panels of witnesses, one on challenges facing us in children's health, and then one on pressing problems in women's health. On each panel, we will at least have one representative from the CDC who will outline the agency's responses to these challenges.

I do want to urge all of our witnesses—and we have got some real experts here—to summarize as much as possible so we will have ample time for everyone. The complete statements, of course, will be made a part of the record, but that will give me a chance to ask some questions and react a little bit.

This is Janet Abrams from Atlanta who does all my appropriations work, and has helped considerably in the preparation of these hearings.

STATEMENTS OF:

DR. GINGER FLOYD, DIRECTOR OF THE FAMILY HEALTH SERVICES SECTION, GEORGIA DIVISION OF PUBLIC HEALTH

BARBARA CHAMNESS, EXECUTIVE DIRECTOR, CHILDKIND, INC.

DR. PAUL WIESNER, DIRECTOR, DeKALB COUNTY BOARD OF HEALTH

DAVIS COOPER, JR., PRINCIPAL, TILSON ELEMENTARY SCHOOL, DECATUR, GA

DR. STEPHEN THACKER, DIRECTOR, CDC'S EPIDEMIOLOGY PROGRAM OFFICE

INTRODUCTION OF PANEL 1

Senator FOWLER. For our first panel we have Dr. Ginger Floyd, director of the family health services in the Georgia Division of Public Health, who will discuss risks to neonatal and infant health; Barbara Chamness, founder of the organization ChildKind, will address the critical problem of caring for children with AIDS; Dr. Paul Wiesner, who is director of the DeKalb County Board of Health, will comment on threats to the health of young children in the preschool years; Davis Cooper, Jr., principal of Tilson Elementary School in Decatur, is going to talk about the challenges facing young people as they develop their health habits; and Dr. Stephen Thacker, Director of CDC's Epidemiology Program Office, will highlight the agency's efforts in preventing disease and injury among children.

STATEMENT OF GINGER FLOYD

Let us begin with Dr. Floyd. Thank you so much for being with us.

Dr. FLOYD. Thank you.

Well, good morning.

A special thank you to the committee members and the Centers for Disease Control for hosting such a very important conference, for indeed the children of our State and Nation are the very future of this country.

I am not going to use my 3 minutes to discuss the problems of infant mortality in Georgia; they are well delineated in my written testimony. Suffice it to say that simply too many Georgia babies are continuing to die before they reach the age of 1. In 1989, 1,379 babies died, almost 4 every day. Georgia and her southern neighbors make up the infant mortality belt of the Nation where infants have the highest risk of dying before they are able to blow out their first birthday candle. In this State as in the Nation, a black baby has twice the chance of dying than a white infant before they reach the age of 1.

Substance abuse and sexually transmitted disease, inadequate maternal nutrition, all, including poverty, unemployment, education, contribute to the infant mortality problem. So what do we need to do?

I believe that we have to assure access to quality prenatal care and delivery services for all pregnant women in the State of Georgia and the Nation. There should only be one eligibility criterion for receiving prenatal care in this country, and that is that you are pregnant. We must address the real issue of true access, places of service, times of service, manner in which services are provided, by whom the services are provided, culturally relevant services, cost of services, and comprehensive natures of services.

We applaud the Healthy Start Initiative that has recently been announced by Dr. Sullivan's office, particularly the comprehensive one-stop shopping.

The measure determining access oftentimes is the financing of health care. We applaud the expansion of Medicaid coverage to 133 percent of Federal poverty, and trust that the Congress and States will see fit to expand that up to 185 percent for all pregnant women and infants up to the age of 1.

We also look to the Federal Government to provide leadership in the areas of health care coverage for those women and children who are above the 133 percent of poverty level, either through Medicaid buy-in programs, for employer-assisted insurance programs, or assisting States to provide universal access coverage.

The issue of medical liability and related topics must continue to be addressed; it has not gone away and has a major impact upon true access, particularly in the issue of obstetric care.

The indigent care trust fund, contrary to popular belief, was a very well utilized system in the State of Georgia. We used it to expand Medicaid services for pregnant women through the statewide initiation of perinatal case management program. We paid for postpartum home visits and services to provide access for first trimester entry into care. We strongly recommend that Congress continue this very useful funding mechanism if at all possible to States.

We request that Congress consider the full appropriation of the maternal and child health block grant. This fund to States funds the basic core of material and child health services, and plays a major role in the infant mortality reduction campaign of Georgia and States throughout the Nation.

We would like to consider and speak specifically to the issue of full funding for the WIC Program, the Women's and Infant Children Program, which is a food nutritional supplemental program. Georgia has the ninth largest WIC Program in the Nation. We serve 170,000 WIC clients per month, we have a budget of approximately $100 million which is Federal funds and infant rebate formula funds, and with those dollars we are only able to serve one-half of those who are eligible for this program.

The data shows that WIC works. If in fact you are a pregnant woman on WIC for 5 months, particularly if you are a black pregnant woman in the State of Georgia, you have an infant mortality rate that is one-half of the average black infant mortality rate. WIC works, it is cost effective, and we would like to ask Congress to completely fund it as it sees fit.

The issue of minority infant mortality is one that is particularly interesting to the State of Georgia, as 27 percent of our population is Afro-American as compared to 12 percent of the Nation. It is clear that Congress must support the establishment of State-level offices of minority health similar to the recent efforts that we did in rural health care. This would be very helpful to States such as Georgia where we have a large percentage of Afro-American and other minorities in the State.

The issue of substance abuse and prevention, a very big issue. We believe that that is what leveled off infant mortality in the State of Georgia, we believe we walked right into crack cocaine, tobacco, and alcohol, and it has proven that those women who are substance abusers are less likely to get prenatal care and have worse outcomes of infant mortality.

We know in Georgia that in 1989, we showed that women who smoked during pregnancy were more likely to have a baby who was low birthweight. Dr. Roper is correct; smoking cessation programs do work. We believe that in 1985, it cost the State of Georgia $28.5 million in terms of an effective maternal smoking program.

We support the antitobacco campaign as we recognize the damage that tobacco is doing, and we would like to request that smoking cessation and tobacco cessation programs be a part of all perinatal health care programs, and there are other drugs, the legal ones, the alcohol and tobacco that we must pursue, and someone later will talk about fetal alcohol syndrome in our State.

We would like to talk about the issue of prevention of unintended pregnancies. Over one-half the births in this Nation are in fact unintended. In Georgia we served 225,000 clients in our family planning programs throughout the State last year, but we know that in 1988 there were 680,000 women who wanted not to become pregnant and did not have good access to services.

We would recommend that Congress would reauthorize title X legislation with appropriate funding levels to meet the unmet needs of all family planning clients.

We, in Georgia, are a part of the WHO Collaborating Center and perinatal care and health services research in maternal and child health. This is made up of us in the Georgia Department of Human Resources, Emory University, and the Centers for Disease Control. This is one of our quiet kept secrets in the State, and we would like to consider additional funding which would help, particularly as it relates to the issue of health manpower and training in this State.

Georgia is a unique State. We have four medical schools in this State, multiple nursing schools, an area health education center system, and a lot of allied training centers, but the issue regarding manpower, especially the current nursing shortage and the lack of minority health care personnel is significant for the State of Georgia.

We, in Georgia, in the public health department system service 20 percent of all the clients in the State. We do it with 1,300 public health nurses, and there is a major crisis in the shortage of nurses.

Congress should support continued health professions education through scholarships and loans, the National Service Care Program, the AHAP programs, H–COP, and other programs.

We would like help in breaking through the redtape issue, that administrative gap. Recent efforts in the State of Georgia have helped us streamline some of these eligibility issues, but there remain too many forms, too many unnecessary questions, and too many administrative barriers for pregnant women and children in my State.

A major problem remains. Federal programs such as Medicaid, WIC, and AFDC all have different guidelines and eligibility criteria. It is very difficult to have a clerk at the front desk know that a pregnant Mrs. Jones is a family of one in WIC, but she is a family of two in Medicaid; we count her pickup truck as an asset in one program, but not another; and those examples go on and on and on. We truly need some help from the Federal level in improving the health of mothers and children through getting rid of this redtape.

Last, but not least, community empowerment. This truly is the answer to our infant mortality problem. Babies die one tragic death at a time in my State, county by county, town by town. We know where the babies are dying, we know why the babies are dying. Community-based culturally specific partnerships would be the source of problem resolution. This means that we at the national and State level will have to begin working with communities and people that we have yet to meet. We will have to think old and new thoughts new ways. It is obvious that business as usual is not working.

A radical restructuring of not only the way we think, but the way we provide services is mandatory. We must expand our health care team to not only provide the right message, but to be the right messenger.

Infant mortality is more than a medical model, it is a socioeconomic culture problem with severe health outcomes. We must continually address those problems that never seem to go away in our society—the racism, the classism, the sexism that exists in our Nation, and seek to alleviate their impact upon our babies born and yet unborn.

PREPARED STATEMENT

I would like to thank the Senate Appropriations Committee, the Centers for Disease Control, and all of you for coming today for holding this very important meeting. The very future of our Nation is the topic of today's discussion, our children.

Thank you.

Senator FOWLER. Thank you, Dr. Floyd.

I want the Guinness people to know that the spoken word per minute record held by Billy Graham has been defeated. [Laughter.]

Dr. FLOYD. I had a lot to say in 3 minutes.

Senator FOWLER. I think we are going to have to relax the time limits in order to prevent heart attacks from recorders and signers. [Laughter.]

A great job, Dr. Floyd. Thank you very, very much.

Dr. FLOYD. Thank you.

Senator FOWLER. I do have a few questions, but I think we will get all the testimony in first. Thank you very much.

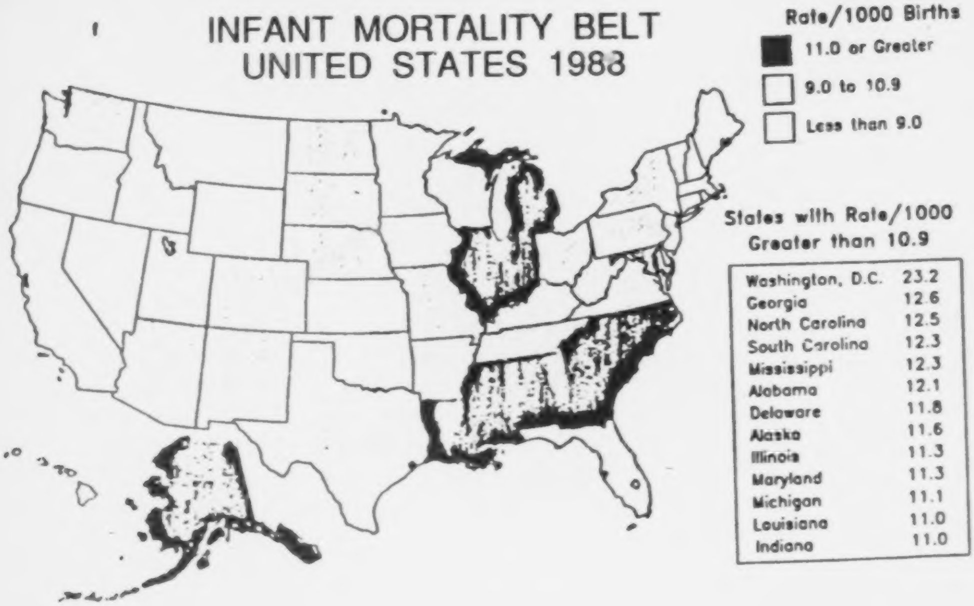
[The statement follows:]

STATEMENT OF DR. VIRGINIA DAVIS FLOYD

"WOMEN AND THEIR CHILDREN: PREVENTION FOR A HEALTHY GEORGIA"

GEORGIA'S INFANT MORTALITY ISSUES

Simply stated, too many Georgian babies are dying before they reach the age of one--1,355 infants died in the state of Georgia in 1989, 1,379 in 1990--almost 4 babies every day. Utilizing 1988 infant mortality statistics, Georgia ranked 50th in the nation in infant mortality with an infant mortality rate of 12.6 deaths per 1,000 live births! Georgia and her southern neighbor states make up the "infant mortality belt" of the nation. Of the ten states where infant mortality rates are the highest, eight are in the South. This belt is also known as the poverty belt, the under-education belt, the rural belt, the unemployment belt and the minority belt--all factors which contribute to our infant mortality crisis.

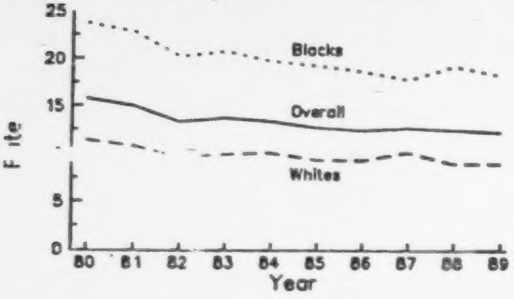

INFANT MORTALITY BELT
UNITED STATES 1988

States with Rate/1000 Greater than 10.9

Washington, D.C.	23.2
Georgia	12.6
North Carolina	12.5
South Carolina	12.3
Mississippi	12.3
Alabama	12.1
Delaware	11.8
Alaska	11.6
Illinois	11.3
Maryland	11.3
Michigan	11.1
Louisiana	11.0
Indiana	11.0

The Georgia Department of Human Resources maintains infant mortality reduction as one of its top priority programs and has undertaken a statewide, department wide initiative throughout the last decade. The Georgia Division of Public Health completed a ten year retrospective analysis of our infant mortality status in collaboration with the Centers for Disease Control and the March of Dimes Birth Defects Foundation, Infant Health in Georgia: Progress During the 1980's--A Database for Heatlh Planning During the 1990's. (abridged edition attached) The infant mortality rates for both blacks and whites have decreased during the past decade. The overall infant mortality rate declined 20% between 1980 and 1985, and then declined only 3% over the next five years. In 1989 the infant mortality rates reveal that black infants continue to experience twice the rate as white infants. The fact remains that a black infant in Georgia, as in the rest of nation, has twice the chance of dying before the age of one than a white infant. In our state last year, 53% of all the babies who died (722) were African American children. Georgia's black infant mortality rate for 1989 was 18.3 deaths per 1,000 live births.

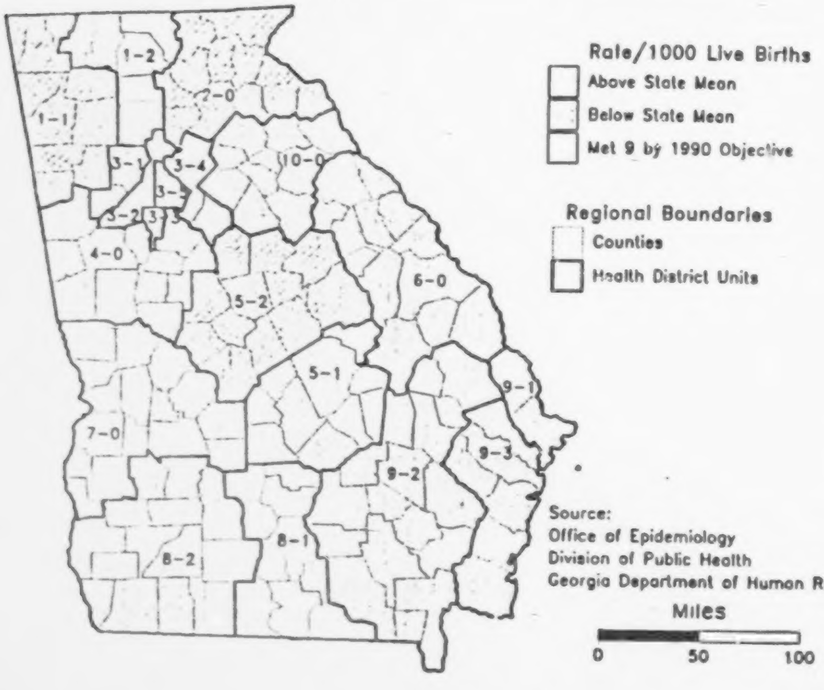
Infant Mortality Rates,* by Race—
Georgia, 1980–1989



* Per 1,000 live births.

Although our white population in Georgia reached the nation's goal of 9 deaths per 1,000 live births in 1988 ("Nine by Ninety"), our overall state and black infant mortality rates will not succeed in obtaining the state and national goal. Three health districts in 1989 met this overall goal.

Infant Mortality Rates in Georgia
by Health District Unit, 1989

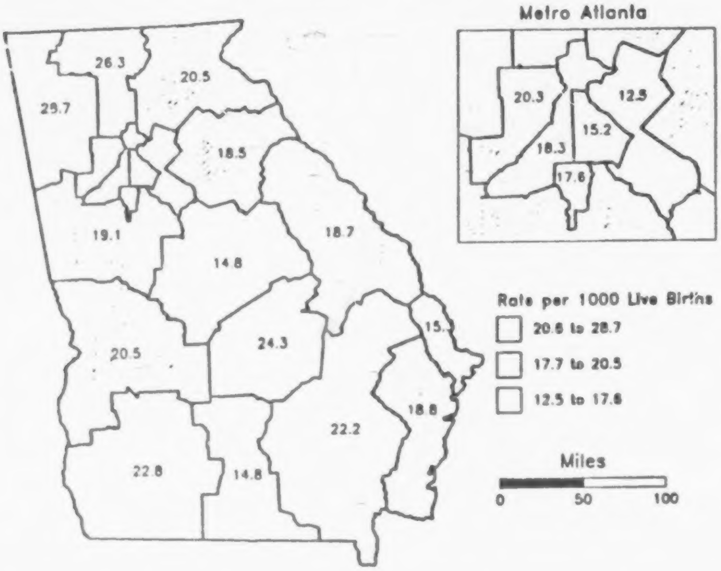

1-2
2-0
1-1
3-1
3-4
3-5
3-2
3-3
10-0
4-0
5-2
6-0
5-1
9-1
7-0
9-3
9-2
8-1
8-2
Rate/1000 Live Births
Above State Mean
Below State Mean
Met 9 by 1990 Objective
Regional Boundaries
Counties
Health District Units
Miles
0
50
100

Source:
Office of Epidemiology
Division of Public Health
Georgia Department of Human Resources

Preliminary 1990 infant mortality figures reveal no statistical change with an overall state rate of 12.3 deaths per 1,000 live births (white rate 9.0--black rate 18.1)

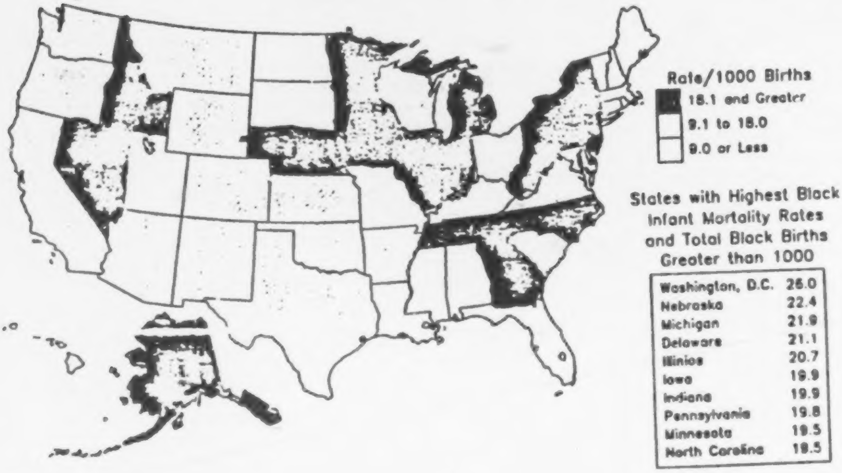
An important factor in Georgia's overall high infant mortality rate, is the fact that our state has such a large African American resident population. Overall the national percentage of African American population is 12% compared to Georgia's percentage of 27. The black/white infant mortality ratio for Georgia is 2.06. The gap in black white infant mortality rates has remained consistent througout the history of record keeping in the state. If Georgia is to make any progress towrd the National Objectives for the Year 2000 of an infant mortality rate of 7.0 deaths per 1,000 live births, our black white infant mortality gap must be closed. We cannot reach the goal with the current gap ratio, as white infant mortality would have to go below an irreducible and unobtainable level. Obviously with such a large minority population, targeted efforts must be instituted to address this critical population.

Black infant Mortality Rates by Health District Unit
Georgia, 1989



Even though Georgia ranks as one of the worst states for overall infant mortality, it does not rank in the top ten states for specific black infant mortality. However, we realize that this nation and state cannot address the issue of infant mortality without specifically addressing the multiple factors of black infant mortality. We are extremely pleased with the technical assistance, advice and support we have received both from the DHHS Office of Minority Health (William Robinson, MD, MPH, Director) and CDC's Office of Minority Health (Ruben Warren, DDS, DPH, Director). Recognizing not only the issue of infant mortality, but the overall larger gaps in health care indices, Georgia's Divison of Public Health has begun a minority health initiative which we plan to expand into an Office of Minority Health.

Infant Mortality Rates among Blacks
United States 1988



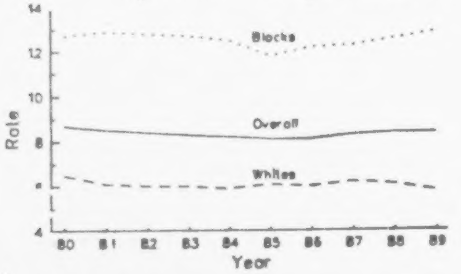
States with Highest Black Infant Mortality Rates and Total Black Births Greater than 1000

Washington, D.C.	26.0
Nebraska	22.4
Michigan	21.9
Delaware	21.1
Illinois	20.7
Iowa	19.9
Indiana	19.9
Pennsylvania	19.8
Minnesota	19.5
North Carolina	19.5

Why do babies die?

The data clearly outlines multiple causes of and contributing factors to infant mortality. The major cause of infant mortality is clearly the problem of low birthweight and prematurity. **Babies born too soon, too small and too sick!** Collectively we utilize low birthweight (defined as weighing less than 2500g) and very low birthweight (defined as weighing less than 1500g) as the major risk factor of infant mortality. Nationally low birthweight infants comprise only 6.9 percent of the births yet account for two thirds of neonatal deaths. In Georgia the low birth weight rate has not significantly changed in the past decade. The percentage of infants weighing less than 2,500 grams at birth declined slightly in the early 1980s in Georgia and increased during the late 1980's. Overall, the low birthweight rate improved slightly for whites and worsened slightly for our black population.

Trends in Low Birthweight Rates*
by Race — Georgia, 1980–1989



* Per 1,000 live births.

Not only is low birthweight the most important cause of infant mortality, it also significantly contributes to the prevalence of chronic disabling conditions such as cerebral palsy, seizure disorders, blindness, mental retardation, behavioral problems and learning disabilities.

What causes lowbirthweight?

Again, the data point to the multiple causes of low birthweight infants--most of which are preventable:

- Lack of quality prenatal care
- Poor maternal nutrition
- Maternal substance abuse (drugs, alcohol,tobacco)
- Sexually transmitted diseases (AIDS,syphilis,etc)
- Unintended pregnancy
- "Isms"--racism, classism, sexism
    - poverty
    - undereducation
    - un/underemployment

It is not the intent of this testimony to outline the specific problems--the statistics are presented in the accompanying document, Infant Health in Georgia:Progress During the 1980s. We would like to specifically address the individual components and make specific recommendations to the the Committee for use in national policy and program planning.

Topics/Issues/Recommendations

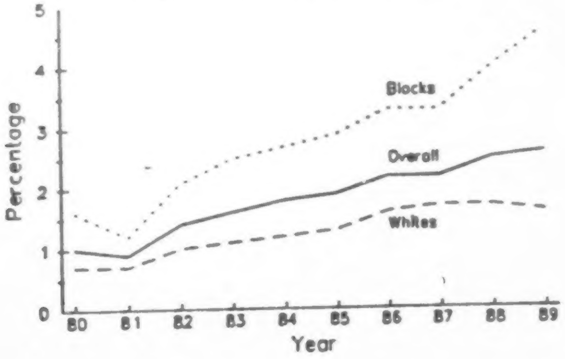
The problems influencing infant and maternal health are truly complex and will require a multifaceted approach for a true solution. However, many of the answers we already know--we simply must assure that they are put into place and implemented. In some cases additional resources will be required- but does this country or state have a more important priority in which to invest than its very future--its children? To solve other aspects of the problem we need asistance in removing the adminsitrative barriers that get in the way of serving mothers and children. Let's examine what Georgia can and must do if we are to assure a healthy beginning for all children within our state.

ACCESS TO QUALITY PRENATAL CARE & DELIVERY SERVICES FOR ALL PREGNANT WOMEN IN THE STATE OF GEORGIA

There should only be one eligibility criteria/requirement for receiving quality prenatal care and delivery in this state and nation--simply that one is pregnant! Universal prenatal care must remain our state and nation's ultimate goal.

The Georgia statistics reveal that we are not close to meeting this goal in our state. During the past decade no prenatal care rates went up for both black and white pregnant women.

Percentage with No Prenatal Care, by Race — Georgia, 1980-1989



We must address the real nature of "true access":

- o place of services
- o time of services
- o manner in which services provided
- o by whom the services are provided
- o culture revelancy of services
- o cost of services
- o comprehensive nature of services

We applaud Dr. Louis Sulllivan's Healthy Start Initiative, as it will allow the grantee to provide truly comprehensive, integrated maternal and child health services. We trust that oen of the ten targeted sites for this comprehensive infant mortality program will be in our state of Georgia. However, if we as a nation are truly serious about this problem, it will be necessary to target the nation--not just ten selected sites.

The major determinant of access oftentimes is access to a method of financing the health care and related services. the issues involved in financing are multifactorial. Specifically, we would like the committee to consider the following:

Medicaid Expansion:

It is obvious that Congress was the force behind the Medicaid expansion to 133% of federal poverty for pregnant women and infants. We also recognize the tremendous burden that continued federal mandates place on our states during this period of fiscal restraint. However, it is evident that the most current mechanism at our disposal to assure more pregnant women access to prenatal and delivery services is continued Medicaid expansion.

The federal government must provide leadership in the areas of health care coverage for those women, children and families above the 133% federal poverty level - either through Medicaid buy-in programs, employer assisted insurance programs or assisting states to provide universal coverage.

The issue of medical liability and related topics must continue to be addressed in light of its impact upon true access to care for our indigent populations.

Indigent Care Trust Fund:

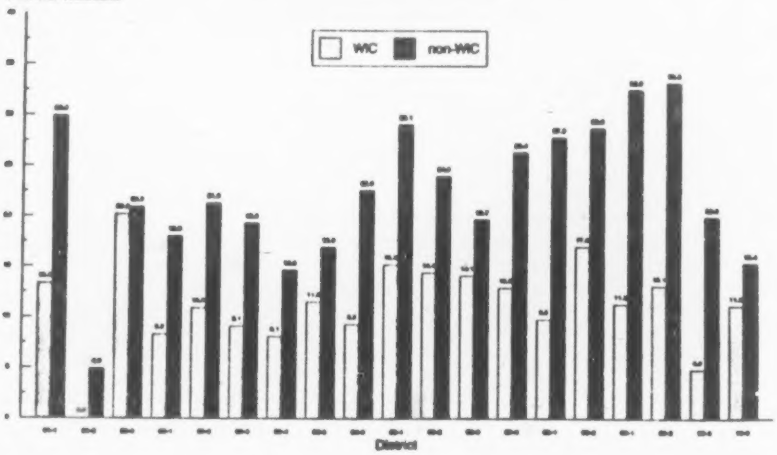
Contrary to popular belief this funding mechanism was well used in my state of Georgia to markedly expand services for pregnant women and children. The state mandated a set aside for the provision/expansion of primary health care services. A portion of these monies was used to provide perinatal case management services for Medicaid eligible pregnant women and infants throughout the state of Georgia. This mechanism also was used to pay for postpartum home visits, incentive fees for first trimester care to physicians and parenting classes. We strongly recommend that Congress continue this very useful funding mechanism to states.

We request that Congress appropriate and fund to the full authorization level the Maternal and Child Health Block Grant. These monies are extremely important to states and serve as the foundation for MCH activities targeted to the reduction of infant mortality.

FULL FUNDING OF THE WOMEN, INFANTS AND CHILDREN'S PROGRAM (WIC)

Georgia has the 9th largest WIC program in the nation currently serving over 170,000 clients per month. Congress has heard much testimony on the need to fully fund the WIC Program. The data in Geqrgia is truly astounding and attests to the fact that WIC is one

of the best, cost effective, health ensuring programs that we have in our infant mortality campaign. In short, WIC works! Georgia completed a three year analysis of WIC participants linked to the birth/death file and found that being on WIC markedly lowered infant mortality rates for our African American pregnant population. Comparing WIC to non-WIC participants, it is evident that infant mortality rates for WIC participants are significantly lower than women who do not access the WIC Program. Black infant mortality rates for WIC participants fell as low as 4.9 in one district, with an overall average almost half of our state's normal black infant mortality rate.



Georgia, 1985 - 1988
Infant Mortality Rates for Blacks
WIC and non-WIC Participants

Through federal funding and the infant formula rebate program the Georgia WIC program budget will be approximately 100 million dollars, serving 193,000 monthly by year's end. However, that amount will only allow the state of Georgia to serve approximately one half of all eligibles. **We know that this program makes a different -- it needs complete funding by Congress.**

TARGETED MINORITY INFANT MORTALITY PROGRAMS

It is clearly obvious that the rates of infant mortality and poor child health outcomes are higher in our minority populations. For my state of Georgia, our African American communities require special targeting efforts and culturally specific intervention programs. Congress must support the establishment of state level Offices of Minority Health, similiar to the recent successful efforts in the area of rural health. Funding to help states establish and maintain such offices would be of utmost value to states with high minority populations such as Georgia.

SUBSTANCE ABUSE PREVENTION & TREATMENT

Much has been recently reported regarding the issue of maternal substance abuse and its impact upon infant mortality and morbidity issues. Preliminary data from one study in Atlanta suggest that mothers who use cocaine are more likely than those who don't to have had no prenatal care and to have had syphilis or HIV infection. Their infants have lower birthweight, require longer hospitalization, and are more likely to die before leaving the hospital.

We are acutely aware of the impact that maternal tobacco use has on infant mortality. Attached to this testimony are reports, "Low Birthweight among Smokers and Nonsmokers in Georgia" and "Low Birthweight among Smokers and Nonsmokers in Georgia by Education of Mothers". The 1989 Georgia birth data show that infants born to women who smoked during pregnancy ar emore likely than other infants to have a low birthweight. In 1989, Georgia mothers who smoked while pregnant bore 2,294 low birth weight infants. We estimated that over 1,000 of these low birthweight infants whould have been born with normal weight if their mothers had not smoked while pregnant. We believe that if we could eliminate maternal smoking in Georgia infant mortality would be reduced by 10% for both blacks and whites. In 1985 it was estimated that the effect of maternal smoking on infants cost Georgians $28.5 million.

We know the simple fact that the more a women smokes during pregnancy, the lower her infant's weight will be. On the other hand, if a women gives up smoking early during pregnancy, her risk of delivering a low birthweight infant approached that of a nonsmoker.

We totally support the Secretary's anti-tobacco campaign as we recognize the damage that it is doing, not only to our children but to all citizens. Tobacco cessation programs whould be a routine part of all perinatal health programs.

Likewise, we must address the other major "legal" drug of alcohol and the damage that it is doing to the children of our state. Conservative estimates put fetal alcohol cases minimally at 500 cases per year in Georgia. This syndrome is a major cause of mental retardation and birth defects, and is completely preventable!

It is imperative that the nation comprehensively and decisively address our issues of perinatal substance abuse. Its impact upon infant mortality and related topics such as HIV infection is tremendous. Congress and the state of Georgia must implement special education, prevention and treatment programs for women and their families. All substance abuse program efforts must address not only illegal substances, but include tobacco and alcohol.

Congress should be aware that states are extremely appreciative of the educational and technical assistance provided by agencies such as Office of Substance Abuse Prevention (OSAP), The Office of Treatment Improvement (OTI) and The National Institute on Drug Abuse. An outstanding example of providing very useful information to states was the recently held conference, "The Second National Conference on Preventing and Treating Alcohol and Other Drug Abuse, HIV Infection and AIDS in Black Communities: From Advocacy to Action".

We firmly believe that a combination of prevention and treatment is the answer to this large problem. We do not advocate the criminalization of maternal substance abuse as we feel it will drive women away from the needed prenatal care mandatory for healthy birth outcome.

PREVENTION OF UNINTENDED PREGNANCIES

Over half of all births in this nation are unintended. We often overlook the role that comprehensive family planning programs play in the reduction of infant mortality. One of the best predictors of a healthy birth outcome is whether the birth is a wanted one. Family planning services allow children to be born at the appropriate time - when they are wanted and loved.

In Georgia over 225,000 clients are served annually through our state's family planning programs. In 1988 we estimate that 680,000 women in Georgia were either sexually active teenagers, unmarried women or married women who did not wish to become pregnant. Both the state of Georgia and Congress need to provide additional support to comprehensive family planning programs to assure access to all citizens (both men and women) who wish services. Congress should reauthorize Title X legislation with appropriate funding levels to meet the unmet needs of our citizens.

Attached to this testimony is an article, "Unintended Pregnancy and Infant Mortality/Morbidity" which clearly outlines the connection between family planning programs and infant mortality/morbidity outcomes. This research was conducted by the World Health Organization (WHO) Collaborating Center in Perinatal Care and Health Service Research in Maternal and Child Health - a joint effort of Emory University, Georgia Department of Human Resources and the Centers for Disease Control. This WHO Collaborating Center is one of Georgia's quiet kept secrets which needs additional state and federal support to enhance its capability to provide greater services to the state of Georgia.

HEALTH MANPOWER DEVELOPMENT/TRAINING

Georgia is a unique state in that it is home for four major medical schools, numerous nursing schools, an Area Health Education Center (AHEC) system, and other allied health training programs. The issues regarding manpower - especially the current nursing shortage and lack of minority health care personnel is significant for our state. Georgia's Division of Public Health provides health care services to 20% of the state's population through the public health department system. The majority of that care is provided by a team of 1300 public health nurses. The manpower issues are acutely felt in the areas of obstetric services, nursing and minority health providers.

Congress must continue support to the health professions through both scholarship and loan programs. We support programs such as the National Health Service Corps, AHEC Programs, Health Career Opportunity Programs, nurse midwifery training programs, etc. Congress and the state of Georgia must maintain a long range view in the area of health manpower development.

ADMINISTRATIVE ISSUES/BREAKING THROUGH THE RED TAPE"

Recent efforts in our state of Georgia have been successful in streamlining some of the eligibility application processes. However, there remain too many forms, too many unnecessary questions, too many administrative barriers for pregnant women and children in my state. We are currently working on a uniform eligibility form. A major problem remains - federal programs such as Medicaid, WIC, AFDC all have different guidelines and eligibility criteria. It is difficult to have a clerk at the intake desk know that pregnant Mrs. Jones is a family of one in WIC, but a family of two in Medicaid. We count her pick up truck as an asset in one program, but not another... and the example go on and on. Helping us remove these administrative barriers will go a long way in improving the health of mothers and children throughout the nation.

COMMUNITY EMPOWERMENT

This truly is the answer to our infant mortality problem. Babies die one tragic death at a time in my state - county by county, town by town. We know where the babies are dying - we know why the babies are dying. Community based, culturally specific partnerships will be the source of problem resolution. This means that we at the national and state level will have to begin working with communities and people that we have yet to meet. We will have to think old and new thoughts, new ways. It is obvious that business as usual is not working. A radical restructuring of not only the way we think, but the way we provide services is mandatory. We must expand our team to new members. We must not only have the "right message", we must also be sure that we are sending the "right messenger". Infant mortality is more than a medical model problem - it is a socio-economic, cultural problem with severe health outcomes. We must continually address those problems that never seem to go away -the racism, classism and sexism that exist in our nation - and seek to alleviate their impact upon our babies born and yet to be born.

I would like to thank the Senate Appropriations Committee Centers for Disease Control and all other participants for holding this very important hearing. The very future of our nation is the topic of today's discussion - our children.

ACKNOWLEDGEMENTS:

A special thank you to Roger Rochat, MD, and staff of the Office of Epidemiology; Juanita Blount Clark, DPH, Minority Health Initiative; Brian Williams, MD,. Office of Infectious Diseases and Lori Mayer, March of Dimes.

STATEMENT OF BARBARA CHAMNESS

Senator FOWLER. Next we have Mrs. Barbara Chamness who is founder of ChildKind.

Ms. CHAMNESS. Good morning, Senator Fowler.

Senator FOWLER. Good morning.

Ms. CHAMNESS. Thank you and the CDC for being our host today.

I would like to say to you that I am here not only as the executive director of ChildKind, but as a mother. This morning at 6 o'clock when I kissed that precious little 3-year-old goodbye and headed out the door and he yelled "Mommy," I said, "What, John?" and he said, "I just want you to know I love you very much." John has been in my home since he was 7 days old. The 3 months that it took for him to go through intense withdrawal from his crack cocaine addiction, the bonding took place that should have taken place in the mother's womb, so John is my child in every sense of the word. John does have full-blown AIDS, and so my testimony is not only a testimony, it is a plea as a mother and as a person who lives with a number of children who are impacted by this horrible, horrible virus.

I do want to talk with you today about prevention as care, and care as prevention. The two words go hand in hand. We know that humankind has always found security with the hope that the children are our future, and to assure that hope we must work to assure that future for our children, for all of our children.

But reality intervenes and the devastating facts exist that children are being born programmed even before conception for death at worst, or unacceptable quality of life at best. The reasons are many and varied, including hunger, addiction, homelessness, and ignorance, or lack of personal concern about HIV.

Often these mothers and mothers-to-be have little or no skills in parenting, managing their own lives becomes such a formidable task that reaching beyond themselves becomes impossible. Frequently these mothers are unable to provide the nurture and love necessary to sustain the lives of their children. Therefore, help must be provided to promote these fundamental rights and necessities.

Careful consideration shows that nurture and quality of life for the children are greatly improved when the lives of their mothers are dignified with the basics of care. With this in mind, we maintain that one of the greatest preventions to HIV infection is care for the mothers, care in the forms of prenatal education, help with parenting skills, drug rehabilitation, HIV/AIDS counseling and education, as well as birth control education, but care as prevention must extend beyond the mothers and enfold the children in the arms necessary to sustain their lives.

These arms provide the warm, stable environment tantamount to lives of quality. Quite simply put, these children who receive love and medical care have longer lives. We know that, and we must assure that they have access to this love and to clinical trials across our Nation.

Loving homes for abandoned or orphaned children absolutely must be available. The average cost in Georgia to maintain an asymptomatic child in a hospital is $600 a day. In ChildKind's 24-hour residential situation, it is $100, so right there we know that this is a more economical way to handle the situation, but more importantly the child grows up in a family setting which provides a healthy environment, preventing unnecessary hospitalization.

The way to provide care as prevention is through active and proactive intervention. We must act swiftly to prevent infection through improving our Nation's health care to assure access and quality for mothers and their children.

Women must be made aware and helped to understand the methods and deadly dangers of HIV infection. They must be provided with drug rehabilitation options that are accessible and indeed successful. They need to have—and this is so important—24-hour residential and/or day care services provided for their children in order to allow them to participate in drug rehabilitation or hospitalization for complications of their own disease. It is crucial that mothers have a safe option to placing their children in foster care. Mothers want to keep their children, and we have got to give them a safe option so that they do not feel like they have to give up their children because they feel helpless or they feel hopeless.

Also, the children need to be provided with daily hot meals to ensure growth, development, and stamina to withstand the HIV in their bodies. Right now our agency, because of the calls that we get every single day about hungry children, is in the process of developing a national program of meals on wheels for children. Our children should not suffer because they are hungry.

Considering all of these issues, it becomes apparent that the way to fight this war against HIV and its devastation is to form a united front in every way. We need to provide service providers, we need to work with Government agencies, and, of course, the private sector. From these diverse arenas more resources can be accessed, more needs addressed, and more information disseminated.

PREPARED STATEMENT

In order to win the war we need more money, we need better managed money, and we need more programs designed to address the ever changing face of this enemy, but until such time that our children are no longer stigmatized, suffering, and dying from this totally preventable disease, prevention and care must become one thought, one word, and one action.

Thank you.

Senator FOWLER. Thank you very much, Ms. Chamness.

[The statement follows:]

STATEMENT OF BARBARA A. CHAMNESS

Humankind has always found security with the hope that "the children are our future," and to assure that hope, we must work to assure that future for our children—for all our children.

But reality intervenes and the devastating facts exist that children are being born—programmed—even before conception—for death at worst, or unacceptable quality of life at best. The reasons are many and varied including hunger, addiction, homelessness, and ignorance or lack of personal concern about HIV. Often these mothers and mothers-to-be have little or no skills in parenting. Managing their own lives becomes such a formidable task that reaching beyond themselves becomes impossible. Frequently these mothers are unable to provide the nurture and love necessary to sustain the lives of their children; therefore, help must be provided to promote those fundamental rights and necessities.

Careful consideration shows that nurture and quality of life for the children are greatly improved when the lives of the mothers are dignified with the same basics of care. With this in mind, we maintain that one of the greatest preventions to HIV infection is care for the mothers. Care in the forms of prenatal education, help with parenting skills, drug rehabilitation, HIV/AIDS counseling and education as well as birth control education.

But care as prevention must extend beyond the mothers and enfold the children in the arms necessary to sustain their lives. These arms will provide the warm stable environment tantamount to lives of quality. Quite simply, the children who receive love and medical care have longer lives. We must assure that clinical trials for more children are provided by all states in this country. Loving homes for abandoned or orphaned children must be available. (Average cost to maintain an asymptomatic child in Georgia in the hospital is $600. ChildKind's 24-hour residential care is $100. But more importantly, the child grows up in a family setting which provides a healthy environment preventing unnecessary hospitalization.)

The way to provide care as prevention is through active and proactive intervention. We must act swiftly to prevent infection through improving our nation's health care to assure access and quality for mothers and their children. Women must be made more aware and helped to understand the methods and deadly dangers of HIV transmission. They need to be provided with drug rehabilitation options that will be accessible and successful. They need to have 24-hour residential and/or day care services provided for their children in order to allow them to participate in drug rehabilitation or hospitalization for complications of their own disease. It is crucial that mothers have a safe option to placing their children in foster care or giving them up through a sense of helplessness. Also, the children need to be provided with daily hot meals to insure growth development and stamina to withstand the HIV in their bodies. Our agency is currently developing a national program of meals on wheels for children impacted by HIV.

Considering all these issues, it becomes apparent that the way to fight this war against HIV and its devastation is to form a united front, made up of service providers, government agencies and the private sector. From these diverse arenas more resources can be accessed, more needs addressed, and more information disseminated. In order to win the war, we need more money, better managed money, and more programs designed to address the ever changing face of the enemy.

Until such time when our children are no longer stigmatized, suffering and dying from this totally preventable disease, prevention and care must become One Thought, One Word, and One Action.

STATEMENT OF PAUL WIESNER

Senator FOWLER. Dr. Wiesner.

Dr. WIESNER. Mr. Chairman, thank you for inviting us to this hearing.

I am sure I cannot match Ginger's speed, and I wish I could match Barbara's compassion, because she represents thousands of volunteers and people who work in prevention and care for our children.

I speak here for Mr. Fred Agel, the chairman of the DeKalb County Board of Health, and for our Chief Executive Officer Manuel Maloof who sends his regards.

We are particularly happy, Senator Fowler, for your continued efforts to provide substantive support for the Ryan White Care Act, and we think it is very fortunate that we have you putting the legislation in place to establish a permanent moratorium on the HCFA rule that threatens the indigent health care fund in our State, and we appreciate being invited to this hearing.

The written testimony that I have submitted summarizes many opportunities and needs that we have for prevention in DeKalb County. We need continued support for the well-established programs like immunization. We only had eight cases of measles in DeKalb County in the past 3½ years, and actually we have not had a case this year. We would like to keep it that way.

Georgia does not have sufficient funds to provide the second dose measles vaccine, and we can only provide the new haemophilus influenza vaccine for those 2-month-old children whose mothers bring them to the clinics. We cannot have an outreach program, so there are some real opportunities for prevention——

Senator FOWLER. For lack of money?

Dr. WIESNER. For lack of money.

The DeKalb Board of Health also administers the WIC Program that Dr. Floyd mentioned earlier. We currently serve 10,400 participants in the WIC Program at the DeKalb Board of Health, an increase of 1,200 this past year.

More and more often these families include wage earners who are recently unemployed, or who have had their work hours reduced. DeKalb can serve only one-half of the expected WIC target, and our waiting list grows daily.

Now, one of the best things about the WIC Program is that we can use it to integrate other health programs. We combine family planning, well baby clinics, immunization, EPSDT into that visit, and it really does reduce duplication and encourages women who have made appointments to be able to keep those appointments.

Now, through the indigent health care trust fund the State of Georgia is supporting perinatal case management and increased numbers of postpartum visits, and when we combine that effort with the WIC Program in these integrated services, we think we are making a critical contribution to decreasing infant mortality.

Now, the phrase infant mortality is a sterile one; it in no way reflects the tragedy and the suffering when a baby dies in Georgia.

In the last decade, infant mortality in DeKalb County decreased from 15.6 to 12.1 per thousand live births. Now, this falls far short of the 9 by 1990 goal of the State cf Georgia.

The leading causes of infant mortality in our county are prematurity, low birthweight and related problems, sudden infant death syndrome, and birth defects. Infant mortality rates as throughout the State in DeKalb differ by race, with our African-American population suffering nearly two times the higher rate.

Now, we know the specific strategies that we can reduce infant mortality with. We also know that there are two missing ingredients. The first is sufficient dollars. The second missing ingredient is sustained community ownership of this problem which remains our task at the local level.

We have begun to address many aspects of this problem through our maternal and child health task force and through the Status of Health in DeKalb Project. The latter is a community involvement project modeled after the APEX/PH protocol recently released by the National Association of County Health Officials.

Programs that promote healthy infants and young children should lead to healthy development of older children and adolescents, but our teenage pregnancy statistics record our failures. In 1989, there were 2,118 teen pregnancies in DeKalb County resulting in 1,134 live births and 984 abortions.

Several years ago our Chief Executive Officer Manuel Maloof recognized the importance of this problem and its link to the poverty cycle. The teenage pregnancy task force that he established has initiated many innovative approaches and actually has reduced teenage pregnancies in the target areas.

Now, the board of health provides 35 teen clinic sessions per month in nine different locations. In 1989 alone, our Clifton Springs team facility took care of 4,870 teens with more than 9,000 visits.

Now, this problem of teen pregnancy is complex, but it does contribute to the ongoing suffering of young children and women, and we believe that most physical and psychosocial adolescent problems begin in childhood where patterns are established that lead to teen pregnancy, substance abuse, truancy, delinquency, school failure, and acting out behavior.

In September 1989, with Federal funding the board of health developed a school health program with the city schools of Decatur. During 1990, 1,151 out of the approximately 2,200 students in that school system partook of those clinical services. This is part of a well established large collaborative effort known as the Oakhurst-Decatur network.

Governor Miller recently selected the Decatur school system as one of the pilot sites for his new initiative directed at the services for youth at risk. We need to extend these successful models to all areas of our county.

To switch the subject, injury prevention in children and adolescents is the sleeping giant of opportunity in public health. More DeKalb children and adolescents die from injuries than from any other cause.

In the past decade, 444 children and adolescents died from injuries in DeKalb County, and national estimates applied to those figures would suggest that for every child who dies there are 45 who end up in a hospital and 1,300 who make a visit to the emergency room.

Motor vehicle crashes, homicides, and suicides account for 72 percent of injury-related deaths in DeKalb adolescents and children.

The death and injury statistics cannot possibly capture the emotional impact of such losses in our community. The most tragic aspect is that many of these are preventable. For each of these leading causes of injury and for many of the more minor causes of injury there are specific prevention strategies.

Prevention is the key we believe, but we also believe that early intervention in the course of established disease and disability may often be just as powerful in helping children to achieve their maximum potential. With State support, the DeKalb Board of Health has launched two new initiatives. The first, early intervention at birth or soon thereafter is crucial to the long-term outcome of a child suffering from a developmental disability. Locally, we are implementing Public Law 99–457, the Federal law which mandates States to establish coordinated services for families with a developmentally delayed infant up to the age of 2.

Our second initiative focuses on severely emotionally disturbed children in DeKalb who have been traditionally treated in facilities, in-patient facilities. What has often been lacking for these children is a stable, nurturing home environment. We serve families and foster parents by providing an after-school day program for intensive treatment, role modeling, and socialization improvement, and a crisis intervention team of experienced therapists can go into the home and work with the family when a psychiatric crisis occurs.

Senator Fowler, time does not permit me to highlight all the significant opportunities for prevention in DeKalb County. Thank you for putting the real value of prevention into the spotlight.

The DeKalb Board of Health is committed to providing integrated services that make the most of the contributions of all sectors of the county to the benefits of our children. In pursuit of this goal we are committed to focusing our money where it can do the most good. Our local commitment must be met with Federal and State support for prevention programs proven to be effective, such as the ones I have described briefly here.

I want to close with a plea. The specific prevention programs administered here at the Centers for Disease Control must receive support. Under the leadership of Dr. Roper, the CDC has also begun new initiatives to strengthen the infrastructure of public health in this country. It was CDC, for example, that funded the APEX/PH project that has been so helpful to us in DeKalb and which promises to encourage community involvement across the country. Congress must fund these important priorities also.

PREPARED STATEMENT

Working together at all levels of government, we must make progress in integrating services, in developing programs that are culturally sensitive and specific to the populations we serve, and in the training of staff to carry out the core functions of public health at the local delivery level, for unless we as a Nation continue to support the backbone of our public health system, no community will be able to make its unique contribution to the year 2000 national goals, and our children will suffer.

Thank you for your attention and your interest.

Senator **Fowler**. Thank you, Dr. Wiesner, and thank you for dedicating your career to the improvement of the health of all of our citizens.

I appreciate your mentioning the Ryan White. We did get $6.6 million of—there was only $220.5 million appropriated nationwide, and $6.6 million of that came to Georgia, which is a much larger percentage than most places in the country. Not enough, but we will try to do even better next go around.

[The statement follows:]

STATEMENT OF DR. PAUL J. WIESNER

Senator Fowler, I am Dr. Paul Wiesner, Director of the DeKalb County Board of Health. Thank you for including us in your hearing on *Women and Their Children: Prevention for a Healthy Georgia.* Speaking for Mr. Fred Agel, Chairman of the DeKalb County Board of Health and Mr. Manuel Maloof, Chief Executive Officer of DeKalb County, I can assure you the residents of DeKalb are pleased with your work in the U.S. Senate. We are particularly appreciative of your continuing efforts to secure substantive funding for the Ryan White Care Act, of your legislation to provide a permanent moratorium on the HCFA rule which threatens to eliminate the Medicaid Voluntary Contribution Program and for the leadership in holding this hearing. What better place to hold it than at the Centers for Disease Control: the prevention agency of the U.S. Public Health Services. DeKalb residents take pride in CDC's being located in our county. Georgia is fortunate to be served by you and Senator Nunn.

You requested that today's comments focus on preventable health problems among young children. My remarks will be from the local perspective, not from a narrow or provincial outlook, but from one which is representative of the more than 2,500 local public health directors who lead the unsung heroes of public health. Those unsung heroes include the 900 employees of the DeKalb County Board of Health, the thousands of dedicated workers in collaborating public and private agencies in the county, plus thousands of volunteers and ordinary individual residents who make up local public health in DeKalb. This workforce, with the support of state agencies, forms the backbone of the nation's public health system. This local perspective is not provincial in another sense. It provides a respite from the constant barrage of national and state statistics that tend to numb the populace into inactivity.

The local perspective is embodied in Georgia's 1972 public health statute that captures the essential functions of local public health emphasized in the provocative report, *The Future of Public Health* published in 1988 by the IOM of the National Academy of Science. These essential functions are: community health assessment, citizen-based policy development, and assurance that health needs are met. As a member of the Board of Directors of the National Association of County Health officials, I point with pride to the recent release of the *Assessment Protocol for Excellence in Public Health* (APEX/PH). This powerful tool for use by local public health agencies seeks to empower communities to address health problems in a vigorous, data-driven, and systematic manner. I have shared with your office the recent publications on the *Status of Health in DeKalb* which were developed as part of the APEX/PH process. The Board of Health appreciates assistance from CDC and the Georgia Department of Human Resources Division of Public Health in developing the data used in the report. For policy to be relevant, it must be data driven. Combined with model standards, a method for depicting health objectives specific to each community, APEX/PH can help each county make its unique contribution to reaching the national year 2000 objectives laid out in the HHS publication, *Healthy People.*

The opportunities for preventing health problems among DeKalb's young children are constantly present. Before highlighting some particularly important prevention opportunities, I would like to emphasize our ordinary everyday approaches.

First, the DeKalb Board of Health believes that public health is much more than just what the staff does. Public health is the result of the collective energies of all sectors of the county mobilized to address health problems. For example, under the leadership of the Decatur City School System, we are especially proud to participate in the Oakhurst/Decatur School Network which has recently been selected by Governor Miller as one of the pilot sites for a new initiative directed at services for Youth at Risk. Second, the Board of Health values prevention, but also early intervention and services for those most in need. Third, people do not come in little separate packages of diseases, therefore, the Board of Health is committed to the integration of services. In summary, the approach is to involve as many people as possible in pursuing solutions to problems, to strike an appropriate balance between prevention and early intervention in meeting the needs of those suffering from disease and disability and to integrate individual and community services as early as possible.

Following are opportunities for prevention and early intervention which, if pursued, will improve the health of children and women in DeKalb.

MEASLES

Only eight cases of measles were reported in DeKalb during the past 3½ years. We have had no cases so far this year and would like to keep it that way. But there is reason for concern. There were 365 cases in Georgia in 1990 and 23 cases already in 1991. A 1990 audit of DeKalb day-care centers assessing the immunization status of enrollees indicated only 54.2 percent of centers could show documentation that 90 percent of their enrollees were adequately immunized. The Board of Health held 3 seminars for center operators in April to stress the importance of adequate immunization for all children enrolled and to provide a simple method to track certificates. We are closely monitoring day-care audits for 1991 and sending letters to centers not in compliance with the state law. Legal action may be taken against operators who fail to comply.

Each year an immunization audit is done for kindergarten and first grade students in all schools in DeKalb. Usually over 99 percent of students have either adequate immunizations, a religious or medical exemption, or are within the waiver period for obtaining the certificate.

The Advisory Council on Immunization Practices and the American Academy of Pediatrics recommend two doses of measles vaccine, the first at 15 months of age with a booster between 4 and 12 years of age. The age for the second dose varies between these two recommendations: 4-5 years for ACIP and 11-12 for AAP. The Georgia Department of Human Resources (DHR) lacks funds to implement a mandatory second dose of measles vaccine for entrance into school. Federal funds are needed to implement this two-dose measles vaccine program in Georgia.

HAEMOPHILUS INFLUENZA, TYPE B, VACCINE

H. Influenza, Type B, vaccine has been available for 5 years. It was initially recommended for children between 2 and 5 years of age. As new improved vaccines became available, the minimum age for administration decreased to 18 months and then to 15 months. In October 1990, a new formulation of vaccine (HibTITER) was approved for use starting at 2 months of age. The recommended schedule is 2-4-6 and 15 months of age. In December Pedvax HIB was approved with a schedule of 2-4 and 15 months of age. DHR currently purchases HibTITER and because of the change in the administration schedule, the number of doses required for adequate immunization quadrupled.

Currently all infants coming to Board of Health clinics for immunizations, child health and WIC services are given the HibTITER starting at two months of age. There is insufficient funding to embark on a major campaign to immunize all infants.

Haemophilus Influenza, Type B, can cause meningitis, pneumonia, sepsis, cellulitis and septic arthritis and is most devastating in children less than three years of age. Additional federal funds are needed to provide the vaccine which costs about $9.00 per dose at state contract prices for all infants and young children.

SCREENING FOR LEAD POISONING

In October 1990 the Board of Health restarted lead screening, focusing on children 1-10 years of age seen for EPSDT services. Approximately 250 children are screened each month. We have found no children with a lead level requiring any intervention. (The highest level was 11 mcg% in one child.) The level for treatment is currently 25 mcg% and will soon be decreased to 10 when the new CDC recommendations are released.

By contrast, in Chatham County (Savannah) the Lead Screening Program has been in place since 1976. Approximately 900 children are screened each month. Currently nearly 5 percent of those screened have lead levels requiring intervention. Several years ago this percentage was higher. The intercity historical district is the area most likely to have children with elevated lead levels.

At the present time there is a need to define the high-risk areas in DeKalb. A grant proposal has been submitted to the CDC for funding to do more outreach and testing for lead poisoning by making home visits. The Board of Health is coordinating lead surveillance and treatment activities with the Pediatric Clinic at Grady Memorial Hospital.

ADOLESCENT HEALTH

In 1989 there were 2,118 teen pregnancies in DeKalb County resulting in 1,134 live births and 984 abortions. The pregnancy rate for black teens was 91.1 (pregnancies per 1,000 teen girls) and 18.4 for white teens with a combined rate of 44.6. The Board of Health provides 35 teen clinic sessions per month with at least 1 session per month in 9 health centers. The Clifton Springs Clinic has 5 sessions per week. During FY'90 4,870 teens received services and there were 9,482 teen clinic visits.

Health educators work in schools, recreation centers, churches and on street corners encouraging sexual responsibility, building self-esteem and serving as a resource for questions from adolescents about health problems and other issues affecting youth. These workers refer many adolescents to teen clinics and other Board of Health services.

We believe that adolescent problems (physical and psychosocial) do not begin in middle school or high school. The foundation for problems of teen pregnancy, substance abuse, truancy, delinquency, school failure and acting-out behavior begins in childhood. In September 1989, utilizing federal funding, the Board of Health developed a school health program in the City Schools of Decatur. Nurses and social workers provide evaluation and intervention in 7 elementary, 1 middle and 1 high school.

Over 80 percent of students have submitted consent forms from parents and guardians allowing them to use the school health services. During FY'90 1,151 out of approximately 2,200 students utilized these services at least once. A physician is available two half days per week for consultation. Students are referred to Board of Health teen clinics for family planning services and to other medical resources, and to social service agencies when indicated.

The school health program has been very well accepted by the school staff and parents and could be expanded with additional funding. A free breakfast program was started in one school when half the children were found to be anemic. The Oakhurst/Decatur School Network has also brought many community agencies together to discuss problems of students and families and to develop intervention strategies.

DeKalb Chief Executive Officer Manuel Maloof provided leadership by forming an active Teenage Pregnancy Task Force which has initiated many innovative programs that have reduced teen pregnancies in target areas.

WIC

The DeKalb County Women, Infants and Childrens (WIC) Supplemental Nutrition Program, funded by the U. S. Department of Agriculture, currently serves over 10,400 participants monthly, an increase of 1,200 participants this federal fiscal year. Many new participants are family wage earners who are recently unemployed or have had work hours reduced, reflecting the state of the economy. DeKalb can serve only 50 percent of the projected target population for WIC. Last year the program had a waiting list which will continue in FFY'92 unless the 1992 appropriation is larger than expected.

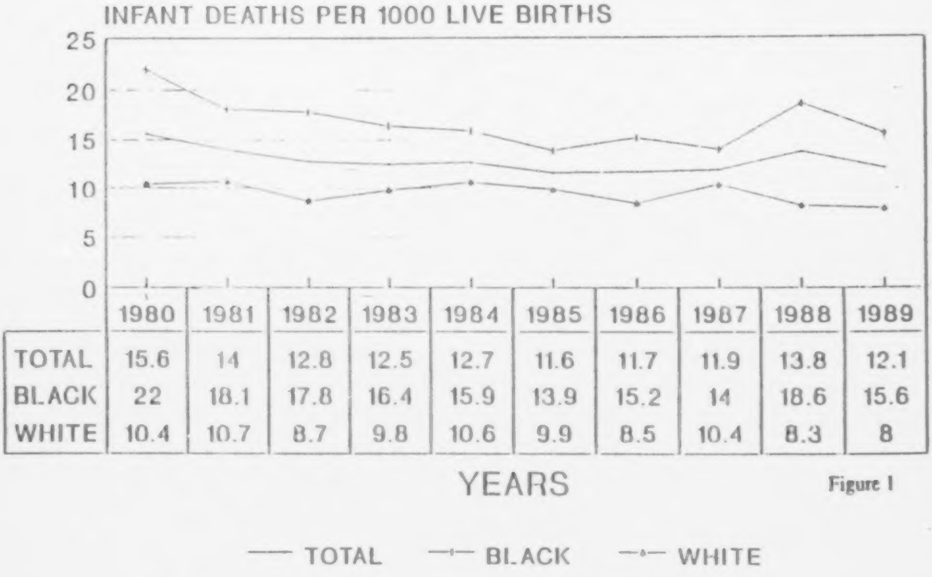
In 1975 DeKalb was one of the first Georgia health districts to offer WIC services. From the beginning, WIC has been integrated with other ongoing health services (Maternal, Family Planning, EPSDT, Well Child and Immunizations Clinics) which allows the participant to receive all services possible during a clinic visit, regardless of the reason for the visit. Integration of services increases kept appointment rates and reduces duplication of services, thus saving participant and staff time.

The Georgia Division of Public Health has recently completed a study investigating birth outcome and WIC participation. The study, which linked medicaid and WIC, found that WIC participants had a lower infant mortality rate than the non-WIC population, furnishing further support for the need for WIC.

INFANT MORTALITY

Between 1980 and 1989, infant mortality decreased in DeKalb County (Figure 1) from 15.6 to 12.1 deaths per 1,000 live births, falling quite short of

INFANT DEATH RATES--DEKALB COUNTY 1980-1989



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989
TOTAL	15.6	14	12.8	12.5	12.7	11.6	11.7	11.9	13.8	12.1
BLACK	22	18.1	17.8	16.4	15.9	13.9	15.2	14	18.6	15.6
WHITE	10.4	10.7	8.7	9.8	10.6	9.9	8.5	10.4	8.3	8

Figure 1

the state goal of "9 by 1990". Infant mortality rates (IMR) in DeKalb differ significantly by race. Rates in blacks have been 1½ to 2 times higher than in whites. Between 1980 and 1989, the IMR in whites declined from 10.4 to 8: while the IMR in blacks declined from 22 to 15.6.

Prematurity and related respiratory problems, sudden infant death syndrome and birth defects are the leading causes of infant mortality in DeKalb. Prematurity is defined as a gestation of less than 38 completed weeks. The cause of sudden infant death syndrome is not well understood. Birth defects and developmental disabilities represent opportunities for prevention and early intervention. For example, the perinatal case management and post partum visits now being supported through Georgia's Indigent Health Care Trust Fund should contribute not only to a reduction in infant mortality, but also help prevent mild mental retardation. Our early intervention program, described later, provides early services to those suffering these disabilities.

Racial differences reflect differential access and utilization of health care services. The difference in IMR between blacks and whites clearly represents preventable infant deaths. In addition, the rate in whites also can be improved.

Low Birthweight is linked to prematurity, the leading cause of infant death in DeKalb. Prenatal care can help prevent low birthweight babies:

- Nutrition service and counseling can improve the nutrition of mothers and their fetuses. The WIC program plays an important role in this regard.
- Medical care for pregnant women can address avoidable health

problems that can impact on the fetus, such as gestational diabetes, anemia, and high blood pressure. Others will testify about the effects of HIV infection on newborns. Special mention must be made of the effect of alcohol and other drugs on the health of children. Fetal alcohol syndrome (FAS) is a major cause of developmental delay. Preventing pregnancy in those who use alcohol or avoiding alcohol during pregnancy will decrease the incidence of FAS. In DeKalb, we are fortunate to be a part of the consortium of substance abuse treatment enhancement supported by the federal Target Cities Grant. This grant supports Project Connect and through it we have access to the Georgia Addicted Parents Program (GAPP). A major emphasis of Project Connect is on improving and expanding enormously needed services for substance abusing mothers.

- Counseling to discontinue use of alcohol, drugs, and cigarettes.
- Teaching parenting skills.

We believe there are specific strategies that can reduce the IMR, but lack only resources and community ownership to effectively address the problem. We are working on the community ownership through our Status of Health Project and hope to compete for available federal funds recently announced by the Health Resource Services Administration for the reduction of infant mortality.

CHILDHOOD INJURIES

More DeKalb children and adolescents die from injuries than from any other cause. Four hundred and forty-four children under twenty years of age died from injuries in the past decade (Figures 2-4). Not only does this represent the loss of 23,293 years of potential life, it also reflects only a portion of the impact of childhood injuries in this community. According to national estimates, each injury death represents 45 related hospitalizations and 1,300 emergency room visits.

Three types of injuries account for 72 percent of the injury mortality among these children: motor vehicle crashes, homicides, and suicides (Figure 5). The most important aspect of this problem is that injuries are preventable; for each of these three leading causes, proven, effective prevention methods exist.

Motor vehicle crashes cause 46 percent of the injury deaths to children, and include drivers, occupants, bicyclists, and pedestrians. A wide variety of

INJURY DEATHS TO CHILDREN--DEKALB COUNTY, GEORGIA
1980-1989

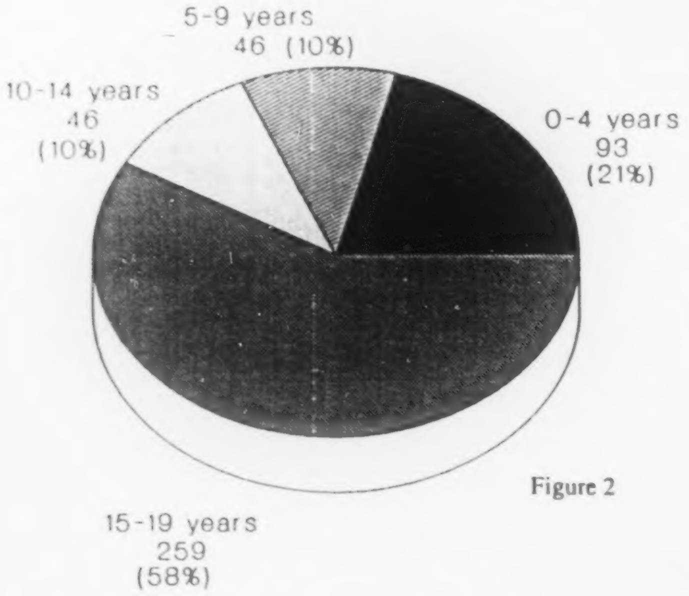


Figure 2

LEADING CAUSES OF INJURY DEATH
DEKALB COUNTY, GEORGIA
1980-1989

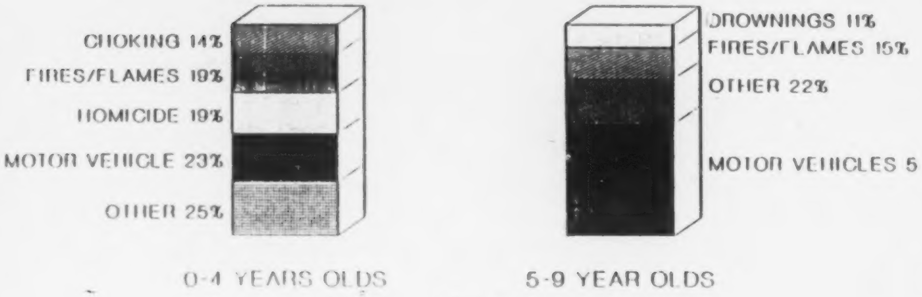


Figure 3

LEADING CAUSES OF INJURY DEATH
DEKALB COUNTY, GEORGIA
1980-1989

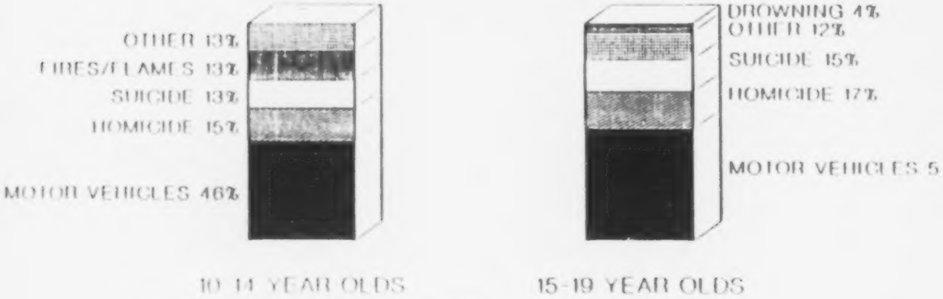
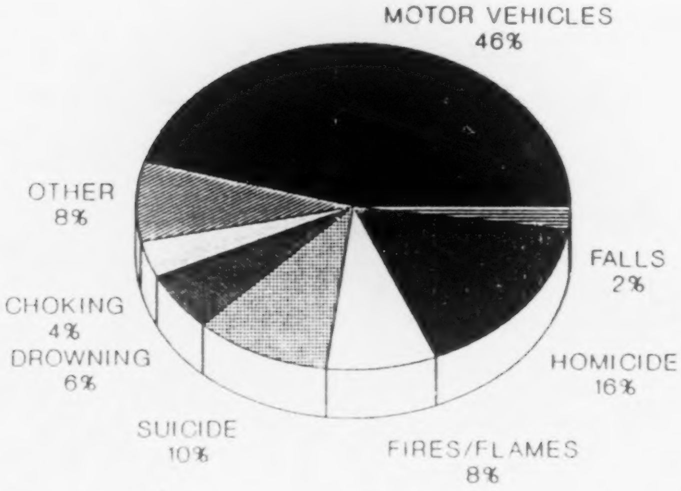


Figure 4

INJURY DEATHS TO CHILDREN BY CAUSE
DEKALB COUNTY, GEORGIA
1980-1989



0-19 year olds

Figure 5

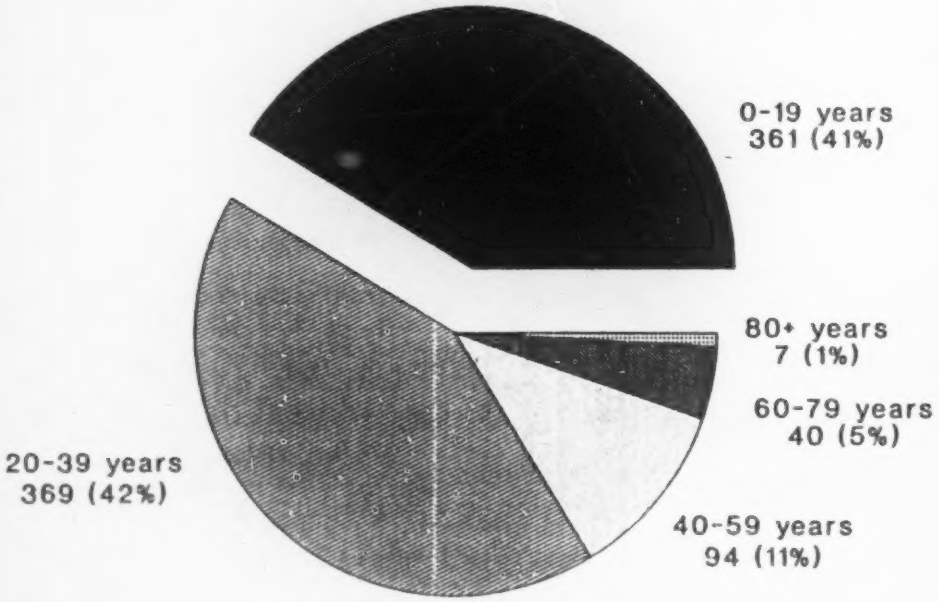
methods have proven to be effective in reducing these injuries, including design and modification of highways and intersections, enforcement of traffic, seat belt, and child restraint laws, educational programs, and the use of protective equipment such as bicycle helmets.

A two year study of injuries to pedestrians in DeKalb shows that 361 (40 percent) of the 871 injury victims were children and adolescents (Figure 6). These injuries can be reduced through the redesign of roadside environments, increased supervision and law enforcement in high risk areas, and educational programs for identified high risk populations.

Homicides comprise 16 percent of the injury mortality among 0-19 year olds, and 19 percent of the injury deaths to children less than five years old (Figure 3). Firearms account for 54 percent of homicides of children under age 20 and 67 percent of homicides overall in DeKalb. Something must be done to reduce the availability of firearms which are killing our young people.

School and community based parenting classes and violence-prevention curricula have proven to be effective in reducing aggressive behaviors that result in violence to children.

Ten percent of injury deaths to children and adolescents are the result of suicide. As with homicide, both school and community based crisis intervention and prevention programs have demonstrated the potential to reduce suicides and suicide attempts.



PEDESTRIAN INJURIES
DEKALB COUNTY, GEORGIA
JULY 1987 - JUNE 1989

Figure 6

The prevention of injuries at the local level requires a combination of resources, community involvement, and interagency collaboration. For example, combined surveillance activities by the Board of Health and the Medical Examiner's Office have created opportunities to study homicides and pedestrian injuries. Safe Kids of DeKalb, a community based childhood injury prevention coalition, provide car seats and smoke detectors for families who need them and presents educational programs to thousands of children. With sufficient resources and support, effective prevention programs can be developed and implemented for each type of injury which affects our children and adolescents.

Another example of broad-based approaches to injury prevention is our DeKalb Prevention Alliance. This group, formed under the auspices of the DeKalb EOA, has recently received a grant from the Office of Substance Abuse Prevention. The goal of this project is to involve our whole county in prevention. We expect to see payoffs in injury statistics from this effort.

Finally, a new innovative approach concerns a specific aspect of the injury problem in our county, namely, family violence. Recently, a Consortium for Public Health was created by the Emory University School of Public Health; the DeKalb, Cobb, and Douglas County Boards of Health; Morehouse School of Medicine and other interested parties. The mission of the Consortium is to establish models of health leadership and problem solving in communities by creating a partnership with local residents. This partnership would assess community awareness and knowledge,identify community values and support the creation of community resources to respond. The Consortium will be guided by a steering committee and will organize its efforts through several institutions. Initially, the Consortium will focus on family violence as a public health issue. We are particularly pleased to see a major commitment on the part of the Kellogg Foundation for supporting this coordinated effort between academic institutions of public health, local health agencies, and community groups.

EARLY INTERVENTION & SEVERELY EMOTIONALLY DISTURBED CHILDREN

With State support, the Board has launched two new initiatives to address developmental disabilities among young children and the needs of severely emotionally disturbed children. Early intervention at birth or soon thereafter is crucial to the long term outcome of a child suffering from a developmental disability. We are involved in locally implementing PL 99-457, the Federal Law which mandates states to establish coordinated services to families with developmentally delayed infants from age 0-2.

Mental retardation specialists combine expertise with other health care professionals to improve early detection and thorough evaluation of the infant and the family situation. Education and involvement in all aspects of the evaluation and planning phases prepares families to make informed choices about services.

Key aspects of this program include establishment of a Transagency Council of 29 public and private services providers, county school systems, parents, public officials, day care operators, welfare agency, hospitals and researchers. This group will adopt guidelines for services and methods of combining efforts in order to stretch the limited resources currently available. Additional funding for direct services would certainly add to the potential of each developmentally delayed child.

The second program focuses on severely emotionally disturbed children in DeKalb who have traditionally been treated on either an inpatient or an outpatient basis. An enormous gap has been the lack of a stable, nurturing home environment for these most-in need children. Recruitment has begun for foster parents who will receive intensive training and on-going support from mental health professionals. These parents will become part of the treatment team and the child will be placed in their home.

Examples of support provided to families of emotionally disturbed children include: an afterschool day program for intensive treatment, role modeling, problem solving and socialization opportunities. An in-home crisis intervention capability provides a team of experienced therapists to go into the home and work with the family when a psychiatric crisis occurs. The situation may require an hour or two or several weeks of reality-based therapy and intervention in the home setting to keep the family together. Therapy and intervention at these crucial times avoid family breakup and placement of children outside the home at great public expense. In addition, this approach defuses the emotions, enables families to grow in their care-taking and enables the child to develop in a more positive, acceptable productive manner.

These programs offer great promise and the support at home allows the children to focus their abilities on school other challenges in their lives.

Senator Fowler, I have only highlighted significant opportunities for prevention, early intervention and services to the most-in-need that are evident to the residents of Dekalb County. Thank you for putting the real value of prevention in the spotlight and for your leadership in emphasizing the need to invest upfront in the well being of our children. The Dekalb Board of Health stands committed to provide integrated services, to maximize the contribution of all sectors of the county to the benefit of our children, and to focus resources where they can accomplish the most. That commitment must be met with federal, state, and county support for the proven effective prevention programs described.

I will close with a plea for continued support for not only these specific prevention programs but also for the commitment at the Centers for Disease Control to improve and modernize the infrastructure of public health in this nation. It was CDC that funded the APEX/PH project. At the local level we need their help in integrating programs, developing programs that are culturally sensitive to populations we serve, and training programs to carry out the core functions of public health at the local level. For unless we as a society support the backbone of our public health system, our children will continue to suffer.

Thank you for your attention and your interest.

STATEMENT OF DAVIS COOPER, JR.

Senator **FOWLER**. Now, Mr. Davis Cooper, the principal of Tilson Elementary School. Mr. Cooper, welcome.

Mr. **COOPER**. Good morning, Senator Fowler.

I want to thank you first of all for the compassion that you continue to show, and the listening ear that I have always seen you give. That I think is one of your fortes.

I also want to thank Dr. Roper, I want to thank the Adopt-A-School contact person Chris Cagle, and CDC members for asking me to participate, and also being the host.

I am to speak on preventable health problems facing today's youth, which are often tied into high-risk behaviors, and as I thought about that I thought about Tilson's adoption by CDC and the fact there was a pregnancy and we had a baby. That baby was approximately 700 students.

I gave them some kids that were in the fast track, but also gave them a lot of kids with major health problems that perhaps are preventable. I feel they are.

In my prepared statement, I talked about 12 or so different major health problems I felt were preventable, but I just want to focus on a few of those in my verbal statement here.

One is illegal drug familiarity. That is a problem that continues to be a problem both on the grade school level and the high school level, and I have served in both areas.

Early sexual exposure and involvement continues to be a problem, and in my years in education I have seen it go down to the lower grades now.

Early pregnancies continue to be a problem. In 1988, the director at the time of the AIDS program here at the Center for Infectious Diseases, Atlanta, GA, made the statement that—paraphrasing him—HIV infections and AIDS will continue to be a major worldwide health problem for the next decade, and we find that to be true.

Violence continues to be a major problem, the homicides, the suicides, and even the incarceration process to me is a form of that.

Poor eating habits, eating less of the things to help one grow strong and healthy, or making poor choices of foods.

Stress. I see younger and younger students undergoing stress-type syndromes.

Injuries continue to be a major problem.

I think about the World Health Organization, Senator Fowler, that says by the year 2000 the attainment by all people of a level of health to include high expectations for healthy lifestyles, et cetera, is something attainable, and I believe that, and I believe that because of several different things that we are currently doing, or some things that have been shared with me that we can do.

One is how can we change lifestyles of young kids. In this country for so long, especially with the baby boomers becoming older, the focus I think has been on older people a lot, or it has been on the WIC Program and younger kids, and somewhere in there I have lost my babies because even though we are teaching them in the public sector—and this came out in the National Commission on the Role of the Schools in the Community and Improving Adolescent Health for Children—we still focus some on those particular problems, but not as much as we should, and in the early 1980's in one of the studies from Washington, I think with the Surgeon General at the time, talked about physical education becoming a pushing point for this country to teach kids things that they needed to know concerning health and other healthy living ideas, but by 1986 in an assessment of that we found that it was not doing the job it should do, so somewhere along the line what I have found is comprehensive health focuses are something that is really being pushed across the country now, and that is basically the understanding that good basic health is a precondition to a child's readiness to learn. We do have a breakfast program at my school, we do teach nutrition, and I can see the difference in some of the kids.

By healthy lifestyles under comprehensive health I think I am talking about enhancing behaviors that will shape consistent internal values where students' attitudes and beliefs are changed somewhat, by health literacy. I think part of the focus is the school also exposing parents to certain programs, and students to certain programs that will help them, but also too giving them the equipment to interpret information and know where to get those services.

One of the things I think about recently is the Medicaid Program, the early and periodic screening and diagnostic and treatment services that can help certain segments of my school, but many times I find that my parents are not aware of those services, so under comprehensive health I think that we can expose them to it, and our role is to point out the importance of preventive care and to guide families to services.

Under the comprehensive information system on our children I think about in my school Dave Paylor interacting with us and exposing us to comprehensive health care, I thought about the fact that there was poor coordination in impacting preventive-type things. What the physical education teacher was doing might not have been something the seventh grade teacher was doing.

Nutrition education and teaching parents and students how to and what to eat, I think, is one of the important components of this too. Under the Comprehensive School Health Program there is a design curriculum I think that is geared to teaching students how to be safe and not receive certain injuries, how not to say yes when they can say no, and also good information on drugs.

Some considerations I guess for me as a principal without going over everything I have written here and really to be more subjective is that as I look at my students each day, approximately 700 of them, I see all students in the State of Georgia and the United States.

As I read health-geared magazines, newspaper articles, and see that this country is at risk again, but it is not an educational risk per se, it is health, I think that good information, teaching, and sharing with students is something we must do, something we cannot delay, and the focus has to again come to teaching children.

No; you will not see short-term results. It is just like teaching, we do not see it until that child is grown, but long-term results are what you will get.

I do believe that the students will impact some parents, but not all, but I think the most important thing by teaching and getting comprehensive health education into the schools those students will impact their children and we will break a cycle and a chain of events and change things for healthy families.

PREPARED STATEMENT

Last, I think of something, and it is not my quote, but it was said to me by an older lady at my school as we had a dialog one day about health problems concerning a child that had a tooth decayed all the way down into the gum, she said "It is better to build children than repair men." I say that to you. I do not think any amount of money in the world can stand in front of teaching students how to live healthy and have healthy lifestyles, and that to me includes more than a healthy body, it includes a healthy mind.

Thank you.

Senator FOWLER. Thank you very much, Mr. Cooper.

[The statement follows:]

STATEMENT OF DAVIS A. COOPER, JR.

First, let me thank you for the opportunity to share one Principal's perspective on our theme, "Women and their children: Prevention for a Healthy Georgia," and in the case of the panel I serve on, my perspective on the subtheme: "Raising Healthy Children".

Being healthy, being in a state of well being mentally, physically, and socially is possible through teaching students via school health education the benefits of healthy lifestyles. We, government and industry, have for many years attempted to impact children's physical health prior to birth with many programs, particularly WIC which counsels with mothers and offers supplemental nutrition provision for the child. However, once the child is here the impact of a well mother having well and healthy strong children who live an adequate quality life begins to wane after 3–4 years.

I am from a town in South Georgia. I have lived and made a career in DeKalb County the past 18 years. in those years that I have served educationally, I have seen the effects of poor "health information" lived out in students and adults. I have seen the fear in young people in health areas because of an inadequate knowledge base concerning healthy living. I see that many of today's children are children of parents whose parents did not share accurate health information with them and the pattern has not yet been broken. But it must be broken. We must find a way to break the cycle and we're asking for that for the children we serve.

When this quality of life for children is not impacted by "prevention challenges" via school health education to teach children the benefits of healthy lifestyles we have the following:

(1) Low self-esteen and poor social relationships; (2) lack of daily cleanliness of the body; (3) poor medical and dental care; (4) late night mentality offering students too little sleep and not enough "growing rest"; (5) illegal drug familiarity and lack of fear of encounter; (6) poor social skills in temperament or the ability to "feel" to be "real" in a relationship . . . Lack of coping skills in conflicts or conflict resolution; (7) early sexual exposure and involvement; (8) early pregnancies as a lack of knowledge or information and/or as a means of gaining acceptance; (9) prone to tobacco, alcohol, drug abuse, and sexual abuse; (10) low trust and high defense; (11) environmentally illiterate or lacking knowledge of environmental health hazards; and (12) too much television; too little reading.

All twelve (12) of these health needs fall under the category of "major preventable health problems" facing today's children. I believe these "major preventable health problems" can be exactly that in the lives of the students Tilson serves via the following:

(1) A comprehensive School Health Education Program; (2) Awareness sessions for teachers as well as teacher training on every grade level; (3) Rewards for follow through for the students (appropriate to the program); (4) Care and genuine concern for the mothers as well as the children by inviting mothers to sit in on classes and listen; and (5) Presenting parent awareness sessions on PTA night(s) to solicit support from parents.

Teachers' training, rewards, care, concern, and parents together with The Comprehensive School Health Education Program can and will expand efforts to that improved quality of life for students at Tilson. Together all of these methods will help young people care enough about themselves to make responsible decisions regarding their health.

I visualize students who say "no" to drugs and understand healthwise what the long term effects of a positive stand in saying "no" means. I visualize students who verbally settle disagreements rather than resort to physical violence. I visualize students who choose to postpone sexual involvement understanding that sex is more than an act and that sexually transmitted diseases are a big reality in today's world.

Because of the above, I visualize students who do not have a casual attitude about drugs or alcohol abuse. I visualize students who are able to function adequately in meeting the needs of their future families (Note: Long term results as opposed to short term results).

I see Tilson as a model for other communities that must have a program which offers to every student at each grade level experiences which add to their choices and opens their minds to healthy lifestyles . . .

In a comprehensive model, we have the opportunity to add to Georgia's health community, preventing a drain on health services for a few women and these children.

In conclusion, we at Tilson thank the Centers for Disease Control members worldwide for their adoption of Tilson Elementary School. Through many volunteer hours, continuous input and concern for Tilson's precious students we see CDC not only as the nation's prevention agency but also as the nation's intervention agency for positive change.

Thank you for allowing me to share my viewpoints on "Raising Healthy Children". May we all see the possibility of a diamond field waiting to be mined for quality school health education.

Remember, "it is better to build children than repair men".

STATEMENT OF STEPHEN B. THACKER

Senator **Fowler**. Finally on this panel we have Dr. Stephen Thacker who is the Director of the CDC's epidemiological unit. Dr. Thacker, thank you so much for being with us.

Dr. **Thacker**. Thank you, Mr. Chairman, for this opportunity to share with you some of the CDC programs in prevention.

I also want to thank members of the panel for articulating the prevention needs and the effective prevention programs that are ongoing in the State of Georgia.

The plea voiced by Ms. Chamness goes beyond AIDS. Between 2 and 3 percent of all schoolage children in the State of Georgia are estimated to have mental retardation, cerebral palsy, birth defects, and other serious developmental disabilities.

Fetal alcohol syndrome, FAS, is the most common cause of birth defects and developmental disabilities. In the United States, an estimated 8,000 children are born each year with FAS.

To put this in perspective, three times as many babies are born each year with FAS as have ever been born with pediatric AIDS.

FAS most severely affects racial and ethnic minorities. FAS is 6 times greater incidence in blacks than whites, and 30 times greater in American Indians.

Systematic smoking cessation counseling for pregnant women works. It has been demonstrated to decrease the occurrence of low birthweight and infant death. An effective national strategy to decrease alcohol use in pregnancy must be developed to halt the tragedy of FAS.

To begin to address the problems of alcohol in pregnancy, CDC hosted in Atlanta last month a national conference on fetal alcohol syndrome. We are also working with the Indian Health Service to evaluate programs to prevent his devastating crisis in American Indian populations.

Let me now turn to an issue of particular interest to parents of small children, child day care.

Currently, 12 million children spend at least 10 hours a week in child care in this country. By the year 2000, three of four women with children under the age of 6 will be employed outside the home, yet children in day care have increased risk of infectious diseases, including immunizable diseases, and up to 5 percent of children in day care centers suffer injuries serious enough to require medical or dental attention.

The economic impact of child day care is dramatic. Over 60 percent of employee absenteeism is directly attributed to unmet child care needs. Parents are forced to miss 1 to 4 weeks of work each year to care for their sick or injured children. Approximately 400,000 medical consultations each year occur at a cost of $4 billion.

CDC scientists have documented the risk of disease and injury related to child care centers. The first population-based study of injury in child care centers was conducted here in Atlanta in the five-county area. We are collaborating in a national effort to develop model health standards for day care centers. In Atlanta in 1992, CDC will cosponsor the first international conference on scientific child day care health.

We are pleased that you are visiting the child day care center we share with Emory and the Egleston Childrens Hospital. In particular, I would like you to take note of the safety features in the playground, a concrete example of translation of research into effective prevention practice.

In Mr. Cooper's words, violence is a major health problem. Among teenagers, homicide and suicide are the second and third leading causes of death after motor vehicle crashes. The homicide rate among young black males ages 15 to 19 has risen 97 percent since 1984. It is more than nine times the rate of white males the same age, and it is hundreds of times the rate of males in western Europe of the same age.

Senator **Fowler**. What are the effective prevention tools to deal with that problem?

Dr. **Thacker**. There are effective prevention tools although you are dealing with a very complex problem. In school health education, for example, conflict resolution is one of the tools we are testing to do this. We have not developed a list of immunizations, or magic bullets. There is no simple solution.

One of the programs that has been shown to be effective involves home nurses who look after and try to care for children who are abused. These same children who were abused in infancy are those who abuse their own children, and are those who commit homicides. Preventing abuse, therefore, will prevent future homicidal behavior.

I think the biggest thing we need to do is develop some community guidelines, and to me the missing ingredient in Dr. Wiesner's words is public education programs that emphasize that violence can be prevented. We do not have the mental set yet that this is a preventable problem, and we need to develop this.

More than 90 percent of the increase in homicide in this country is attributable to firearms. Approximately 60 percent of all youth suicide victims kill themselves with guns. A CDC report released this year indicated that the death rate due to firearms exceeded the death rate for all natural causes of death for both black and white males ages 15 to 19.

As stated by Dr. Floyd the empowerment of communities to take preventive action is essential to the prevention of death and injury. In 1988, in collaboration with teachers, parents, community leaders, and law enforcement officials, CDC published guidelines for the control and prevention of suicide clusters. Together with Morehouse School of Medicine, CDC recently sponsored a forum to develop similar guidelines to empower communities to prevent youth violence in minority populations.

What can we do about the risky behaviors of our children? As Dr. Wiesner asked, how can we help our children reach their maximum potential.

One of the most effective ways is to implement programs of comprehensive school health education from preschool through grade 12. Children can learn decision-making skills that help them make healthy choices—learning to avoid alcohol, tobacco, and other drugs, and potentially to learn to avoid potentially violent situations.

PREPARED STATEMENT

CDC is currently providing support to every State department of education, to 16 local departments of education, and to 25 national health and educational organizations to help the Nation's 100,000 schools to implement effective HIV education programs. We need to build on this.

Through school health education and the many programs you have heard about this morning from the panel we are trying to build a healthier future for our children.

Thank you very much.

Senator **Fowler**. Dr. Thacker, thank you very much.

[The statement follows:]

Statement of Dr. Stephen B. Thacker

CHILDREN'S HEALTH ACTIVITIES AT CDC

I am pleased to have the opportunity to discuss with you the impact of CDC's prevention programs on the health of our Nation's children. As Dr. William L. Roper, Director of CDC, mentioned in his testimony, our efforts touch the lives of our young in infancy, during their formative preschool years, and during childhood and adolescence. We at CDC are dedicated to protecting and promoting children's health; their well-being is a critical value of our society.

INFANT HEALTH

Infant health begins with the mother and family, and CDC's prevention programs reflect this. Over the last two decades, the United States' ranking for infant mortality, that is, death in the first year of life, has dropped steadily from seventh to 24th among industrialized countries. This problem is most serious among black infants who continue to experience twice the rate of death and low birth weight than white infants—a disparity that has remained unchanged over two decades. A white child born in 1970 had a better chance of living to his first birthday than did a black child born 18 years later.

The leading causes of infant mortality nationally are birth defects and prematurity. In Georgia, about 3,800 babies are born each year with a major birth defect resulting in over 200 deaths. Serious illness and disability are also associated with birth defects. Pre-term delivery accounts for nearly 90 percent of excess mortality among infants born to black women.

Almost as tragic as infant deaths are the preventable disabilities endured by our children. Between two percent and three percent of all school-aged children in this state are estimated to have mental retardation, cerebral palsy, hearing or vision impairment, or other major developmental disabilities. Most of these disabilities were present at birth.

Fetal alcohol syndrome (FAS) is the most common known cause of birth defects and developmental disabilities. In the United States, an estimated 8,000 babies are born each year with FAS. To put this in perspective, three times as many babies are born with FAS each year as have ever been born with pediatric AIDS. As with many health problems, FAS disproportionately affects racial and ethnic minorities. The incidence of FAS is 30 times greater for American Indians than for whites and six times greater for blacks than whites. During the past decade nearly 40,000 babies have been born in the United States with spina bifida and related problems. Of these, 15,000 are living with paralysis and other disabilities. Since 1968, approximately 2,400 babies have been born in Georgia with spina bifida; 800 are living today with the associated disabilities.

Scientists and the public alike are acknowledging the unhealthy consequences of cocaine use for pregnant women and their infants. Up to 10 percent of infants born with health problems in inner city hospitals have been exposed to cocaine during pregnancy. The potential societal impact has only begun to be recognized.

Infectious diseases remain a problem of infancy. In the United States in 1990, 2,867 infants were reported to have congenital syphilis. Eighty-four of these infants were born in Georgia. Those who survive often have visual, hearing, and neurologic impairments which have grave implications for the child's learning capabilities.

Group B streptococcal (GBS) disease is the most common cause of infection in infants in the first 30 days of life, causing infections of the skin, soft tissue, bloodstream, and cerebrospinal fluid (meningitis). As many as 15,000 U.S. infants are affected each year. In a recent study in Atlanta, 8 percent of infants with GBS disease died.

So what can be done? Prenatal care serves to introduce known effective interventions to address many of these problems. For example, systematic smoking cessation counseling for pregnant women has been demonstrated to decrease by 25 percent the occurrence of low birth weight and by 10 percent the number of infant deaths.

State health departments need assistance in determining whether failure to reduce infant mortality and low birth weight is due to risky behaviors or ineffective services. At this time, however, only a few states currently have smoking cessation programs. To improve this, we will expand pregnancy risk assessment monitoring systems from 6 to 12 states. Effective prenatal care which includes testing for and treatment of syphilis early in pregnancy is an important step to prevent the devastating effects of congenital syphilis.

On the other hand, much remains to be learned. With funds provided under the 1991 infant health initiative, CDC investigators have undertaken research to determine the causes of pre-term delivery. To begin to address the problems of alcohol in pregnancy, CDC hosted in Atlanta last month a national conference on fetal alcohol syndrome. We are also working with the Indian Health Service to evaluate programs to prevent this devastating crisis in American Indian populations. Epidemiologic studies conducted by CDC investigators from data collected in Atlanta suggest that the use of multivitamins by pregnant women may have a significant impact in the prevention of spina bifida. To confirm the potential usefulness of multivitamins, CDC has begun collaboration with colleagues in China to assess more definitively this finding in a randomized controlled clinical trial. If effective, a global program of multivitamin supplementation in pregnancy could result in the birth of 400,000 children each year who would otherwise die or be born with serious disabilities associated with spina bifida.

Because 25 percent of women carry the group 8 streptococcus bacterium, we recognize the extreme importance of understanding the most effective way to prevent this disease in the newborn. CDC investigators are actively collaborating with others to develop effective ways to prevent infections with this organism.

PRESCHOOL HEALTH

After infancy and before school, our children face another series of health challenges. When I was a boy, the most important problems in early childhood were infectious diseases. Effective childhood immunization programs, however, have dramatically decreased these problems. Measles, mumps, rubella, polio, diphtheria, pertussis, and tetanus have become uncommon conditions because of the effectiveness of these primary interventions. As new vaccines are introduced, such as that for *Haemophilus influenzae* type b and hepatitis B, inroads will continue to be made on infectious disease problems of children. At the same time, we cannot rest easy.

Measles, for example, is a very serious childhood disease that has resurfaced, with significant outbreaks in 1988, 1989, and 1990. While Georgia has not experienced any measles deaths during the past 2½ years, the state did experience explosive outbreaks in 1990 among college students at the University of Georgia and in members of a religious community. Compared to dramatic increases seen in other parts of the country, Georgia has fared rather well; in part, because of the intensive efforts of the state's immunization program. To protect our children, the State Board of Regents recently adopted a pre-matriculation immunization requirement for institutions belonging to the university system. The Department of Education has agreed to support mandatory two-dose measles/mumps/rubella requirements for children entering the sixth grade in 1993, and the religious community in which the outbreak occurred last year has modified their tenets to allow immunizations for all their members.

Similar efforts need to be maintained in all our immunization activities as new vaccines are introduced. The benefits, for example, of our comprehensive, perinatal hepatitis B prevention program would be dramatic. These benefits include the prevention of chronic infections in 6,000 to 7,000 infants, and the prevention of 3,000 to 5,000 infections in household contacts of mothers found to be chronically infected during prenatal screening. The major impact of hepatitis B vaccination will be realized when these children become adults because chronic infection often leads to cancer, liver failure, and death.

Today, we are increasingly concerned about the effect of the environment on our children's health. In the preschool years, probably the most serious environmental hazard is lead. Lead poisoning has decreased dramatically because of the control of lead in paint and in gasoline. Still, in 1984, an estimated 3–4 million children in the United States had blood levels that put them at risk for mental retardation, behavioral problems, and learning disabilities. Once again, this problem affects disproportionately minority children living in the inner city. This is unacceptable when one realizes that childhood lead poisoning is entirely preventable.

CDC has worked with the Department of Housing and Urban Development and the Environmental Protection Agency to control the amount of lead in paint and to develop methods and establish priorities for removing lead from the environment.

Because of these activities, CDC was asked to assume the lead in the development of the Department's Strategic Plan for the Elimination of Childhood Lead Poisoning which was released in February by Secretary Sullivan. The strategy of the Department of Health and Human Services to eliminate childhood lead poisoning includes a grant program administered by CDC to states and cities.

In Georgia, two cities, Augusta and Savannah, have active programs. About 1 percent of children screened in Augusta and 0.3 percent of children screened in Savannah had overt lead poisoning. In addition, 16 percent of children in Atlanta and as many as 19 percent in Macon, Columbus, and Albany have blood lead levels high enough to be associated with decreased intelligence, behavioral disturbances, and other adverse effects.

Let me now turn to an issue of particular interest to parents-child day care. By the year 2000, three out of every four women with children under the age of six will be employed outside of the home. Currently, 12 million children, including four out of every 10 children under five, spend at least 10 hours a week in child care. Yet, leaving your children in a day care facility is not without risk. Children in day care centers have increased risk of acquiring certain infectious diseases, including vaccine-preventable diseases. Up to five percent of children in child day care suffer injuries serious enough to require medical or dental attention. Virtually all these injuries are preventable.

The economic impact of child day care is dramatic. Over 60 percent of employee absenteeism in the workplace has been directly attributed to unmet child care needs. Parents are forced to miss from one to four weeks per year to care for their sick or injured children. Approximately 400,000 medical consultations occur each year at a cost of $4 billion in lost work and medical care. This problem is, therefore, both a social and a public health problem and one that we at CDC feel is essential to address.

Over the years CDC scientists, working with the academic community and state and local health departments, have conducted many studies to help demonstrate the risk of disease and injury in child day care centers. We have cooperated with the academic community and the state and local health departments in this research. For example, the first population-based child day care center study of injury was conducted here in Atlanta. We are working with the American Academy of Pediatrics, the American Public Health Association, and the National Maternal and Child Health Program to develop model health standards for day care centers. In 1992, CDC will co-sponsor the First International Scientific Conference on Child Day Care Health with the World Health Organization, Pan American Health Organization, the American Academy of Pediatrics, the Association of State and Territorial Health Officials, and the Council of State and Territorial Epidemiologists, the National Association of the Education of Young Children, the American Public Health Association and others. We intend to continue to conduct research and stimulate effective interventions.

We are pleased that you will be visiting the child day care center across the street that is used by the children of employees of Emory Universiy, Egleston Children's Hospital, and the Centers for Disease Control which we see as a model of excellence in this field.

HEALTH CHALLENGES FOR YOUTH

The leading cause of death for our children is injuries, both intentional and unintentional. Unintentional injuries result from motor vehicle crashes, pedestrian collisions, drownings, fire, and falls. Intentional injuries include homicides, suicides, assault, and rape. These injuries are dramatic, and, most importantly, we believe that most are preventable if treated as public health problems.

Homicide and suicide are the second and third leading causes of death among teenagers. The homicide rate among young black men ages 15–19 has risen 97 percent since 1984. It is more than nine times the rate for white men the same age in the United States and hundreds of times that of young men the same age in Western Europe.

More than 90 percent of the increase in homicide is attributable to firearms. Firearms account for 88 percent of homicide deaths among black men in this age group. Suicide has also begun to increase in the past decade among those 15 years to 19 years of age. Approximately 60 percent of all youth suicide victims kill themselves with firearms. A recent epidemiologic investigation has suggested that many young people who commit suicide with firearms would not commit suicide at all if firearms were not readily available. A CDC report released this year indicated that 12 percent of deaths in children and youth between ages 1 and 19 resulted from gunshot wounds. In 1988, the death rate due to firearms exceeded the death rate for all other natural causes of deaths for both black and white males between ages 15 and 19. In addition, there are a substantial number of disabilities from nonfatal injuries that place a large health burden on our country.

So what can we do about preventing injury? Many interventions are known to work. Since 1980, more than 1,500 children in the United States have not died as a result of the increased use of child restraints in motor vehicles, use of motorcycle helmets, and enforcement of minimum-drinking-age laws. Consumer product safety laws, regulations regarding swimming pools, and fire-safety activities have all proven effective.

In the area of intentional injuries, however, the problems are more complex. At the same time, research has shown that many of these problems can be addressed effectively. For example, CDC has conducted a study of family and intimate assault in the city of Atlanta which shows that police contacts often precede acts of violence. Information about prior incidence will contribute to preventive efforts by identifying persons at high risk of being victims or perpetrators. In 1989, in collaboration with teachers, parents, community leaders, and law enforcement officials, CDC published guidelines for the control and prevention of suicide clusters, a major problem among our youth throughout the country. Productive interactions among public health, social service, and criminal justice agencies are essential for the ultimate success of efforts to prevent personal and interpersonal violence.

Essential to the prevention of death and injury is the empowerment of communities to take preventive action. Together with the Morehouse School of Medicine, we recently sponsored a forum on the prevention of youth violence in minority communities to develop guidelines for communities to prevent youth violence. At CDC we see this as a critical public health challenge that must be confronted.

A major avenue for addressing many of the health challenges for youth is education. Several key behaviors contribute substantially to disease, disability, and death during childhood and adolescence. These behaviors include failure to use seat belts, use of alcohol or other drugs, and sexual intercourse that can lead to unintended pregnancies and to sexually transmitted diseases, including HIV infection. The leading causes of death for adults have been linked to a limited number of behaviors, often established during their youth. These behaviors include use of alcohol and tobacco, excessive consumption of dietary fat, and insufficient physical activity. Also, much of our infant mortality and morbidity is attributable to behaviors established during youth, especially the use of tobacco, alcohol, and drugs.

We know that our children engage in risky behaviors. In the recent National Adolescent Student Health Survey, 44 percent of tenth grade students reported that during the past month they have ridden with a driver who had used alcohol or other drugs before driving. Eighteen percent of girls and 11 percent of boys reported that they had actually tried to commit suicide. Sixteen percent of eighth graders and 26 percent of tenth graders reported that they were current smokers. One quarter of eighth graders and more than one third of tenth graders recorded having had five or more drinks on one occasion in the past two weeks. Among high school students in a CDC survey, more than half reported having engaged in sexual intercourse. One out of five had engaged in intercourse with four or more partners, and three percent had injected illegal drugs.

What can we do to prevent or change these risky behaviors? The most effective and efficient way to prevent risks is to plan and implement sequential programs of comprehensive school health education for kindergarten through grade 12. Young people must develop the knowledge, attitudes, and skills needed to adopt positive health behaviors. Such programs can be very effective. For example, a CDC evaluation showed that the comprehensive school health education program implemented in elementary schools reduced tobacco use among seventh graders by 40 percent.

What is CDC doing now? We are currently providing support to every state department of education, to 16 local departments of education, and to 25 national health and educational organizations to help the nation's 100,000 schools implement effective HIV-education programs. We are building upon these efforts to implement comprehensive school education programs nationally. It is important to note that virtually all of the national health objectives for the year 2000 depend in some, or large, part on school health education. It is clear, therefore, that fostering effective school health education is an essential part of our mission if we are to succeed in improving the health of our children.

CLOSING

Under Dr. Roper's leadership, CDC has adopted three priorities for the agency—one of these is the enhancement of the health and safety of our nation's children. What I have presented to you this morning is a selection of a wide variety of CDC programs that prevent disease, injury, and disability in children—programs in which we collaborate with our colleagues in state and local health departments, other federal agencies, academia, community-based and voluntary organizations, private industry, and the international community. Thank you for the opportunity to share these exciting activities with you. I will be delighted to answer any questions that you might have.

COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM

Senator FOWLER. Let me begin the questioning just where you left off. How well accepted is this comprehensive school health education program across the country, or I guess to put it another way, either way you want to discuss it, what resistance are you meeting?

Dr. THACKER. Well, I think we have sort of a mix of support and resistance. Comprehensive school health education has been demonstrated to be effective, it works. We have scientific studies which show this, and what we need to do is to empower schools to carry this out in an effective way and broaden it beyond some of the areas where it has worked to areas like violence.

We have to teach kids to know how to recognize and confront challenges in their day-to-day settings, challenges I am sure Mr. Cooper sees even in the elementary schools. Children must be able to confront these situations and deal with them, because if they do not they will respond with anger and with or without firearms other people will be injured, and they may injure themselves.

I think the resistance comes in the potential conflict of home and the schoolhouse. We need to work together as parents and teachers and other educators to recognize what we are trying to do is empower our children to live healthier lives.

Senator FOWLER. Mr. Cooper, do you have a DARE program at Tilson?

Mr. COOPER. Yes, sir.

Senator FOWLER. Tell me about that. What has been your experience, and its success or lack thereof?

Mr. COOPER. Very successful. That is coupled, though, with several other programs, you know, geared toward drug prevention, intervention, prevention and what have you, and that is headed by the lead teacher for student services which is geared toward the counseling concept coming in Georgia.

Additionally, I think too, we have had interaction from CDC along with DARE, so we have had several programs in dealing with drug intervention and other things.

The impact I think it has on students is good information, role models coming outside of the school to talk with the students. That has a tremendous impact, and at the same time too some of the agencies that the kids perceive to be hostile they find that they are people, and basically——

Senator FOWLER. What I wanted, I had not thought about this until I heard your testimony and Dr. Thacker's and anybody else that wants to participate—for those who do not know, the DARE, D-A-R-E, drug abuse resistance education—I have visited several of the schools from south Georgia to north Georgia, and been extremely impressed at, one the ability to engender respect for police officers. I guess most important the success of the program has been based on the fact that they teach these elementary school students how to resist the peer pressure which—now, is that a model for resisting violent behavior in your opinion, Dr. Thacker, or anybody else?

Dr. THACKER. I think it is a good model, it has been demonstrated to be effective, and we cannot start too early with our children in learning these conflict resolution skills. I do not know if others in the State have had experience with these sorts of things.

Dr. WIESNER. Just to throw in a comment here, I think one of the important ingredients in approaching children with health and in a school system is that they do not come in little packages of different kinds of problems, there is a core development there of self-esteem and support systems that is lacking, and I think if we examine all of the problems that young children in school are facing at the core is this loving care and support with giving them specific skills not only to resist substance abuse and illegal substances, but to avoid inappropriate and dangerous sexual behavior, to avoid taking risks that are very, very dangerous to their health, and that core approach, a comprehensive approach that really does treat people and children as whole people is critically important.

Senator FOWLER. Dr. Thacker, I am not going to forget it, but you did not mention it, so it now made the front pages of the paper, we have got between fiscal years 1989 and 1990—I am told by my crack staff here with the help of yours I am sure—that we had a 313-percent increase in the incidence of congenital syphilis.

What in the world are the reasons for this sudden dramatic rise, and how is CDC tackling the problem?

Dr. THACKER. The rise in the incidence of congenital syphilis as you say is dramatic and disturbing. We have had syphilis control programs for many years, and what we have seen in the last several years is a dramatic rebound in the occurrence in adults, particularly in Georgia.

Senator FOWLER. Why?

Dr. THACKER. Because the control efforts that we have focused in on for syphilis have not had the intensity they have had in the past is one reason, but more importantly, I think, is that it is a reflection of the changes in our society over time that we need to recognize and address.

I think the programs in Georgia that Dr. Wiesner can tell you about are an example of how we have to respond to this change.

Senator FOWLER. What is the budget? Do you have that? Is that line-item or earmarked in your budget, that program specifically?

If you do not have it now, you can give it to me later.

Dr. THACKER. The other problem I think we need to mention and not forget about with syphilis is the related drug problem. Crack cocaine, heroine, and the other related drugs are important because not only the behavior is related to drugs, but selling sex for drugs is an important issue that we need to address and intervene on.

Senator FOWLER. Dr. Floyd, I was struck by your comments on infant mortality as well as Dr. Wiesner's putting in perspective that that is a pretty dispassionate description of the extraordinary family and human tragedy that is totally preventable.

In the State of Georgia we have about 70 counties at my last count, maybe more than that, that do not even have a practicing ob-gyn.

Tell us a little bit about the difficulties that women have, the particular difficulties that women have in rural areas of access prenatal care, and what are we doing at the State level and in combination with Federal programs to reach them.

Dr. FLOYD. Well, we believe that access is really the issue, and Georgia is the largest State west of the Mississippi River, 159 counties. There are 110,000 births in Georgia every year.

About 40,000 of those pregnant women get their prenatal care, all or part of their prenatal care in public health departments throughout the State, and that system is a nurse-run system, it is a public health run system with 1,300 nurses who provide that prenatal care for low-risk women.

We have many counties where there are no obstetrics-gynecologist [ob-gyn] providers or family practitioner providers, and the nurse, the public health nurse is the only game in town.

We have areas of the State where if in fact you have a Medicaid card in your hand which we perceive as almost as good as gold we have providers who will not accept that unless under an extreme emergency or as a walk-in in the hospital.

Georgia has utilized nurse midwives, certified nurse midwives, to expand this health manpower pool in some areas of the State. The State funds scholarships for nurse midwives, our Medicaid system pays the nurse midwife the same reimbursement as they pay an ob-gyn provider in an attempt to get women served.

We had a problem in Georgia a few years back where women were having babies in the back of pickup trucks on their way down I–20 trying to get to one of our county hospitals, or in the parking lot because they did not have a Blue Cross-Blue Shield to get into the hospital, and Georgia passed a law that said labor is an emergency and that all hospitals that were equipped with obstetric services could not turn away a woman in labor.

This does a great deal for getting a woman universal access to delivery services, it does nothing for connecting the continuity of care in between which still remains a problem.

Senator FOWLER. Right.

Dr. FLOYD. So as we look at expending services through our expanded role of nurses in the public health department systems, through encouraging ob-gyn doctors back into the Medicaid program the State of Georgia has one of the third highest reimbursement rates for ob-gyn deliveries in the Nation at a rate of $1,205 per normal delivery in prenatal care trying to get private practitioners back into the system and using the expanded roles such as certified nurse midwives to do that, but we still have—over the past decade if you look at the percentage both in the white and black pregnant female populations in the State the number of women, pregnant women, both white and black who received no prenatal care increased over the decade, even with all of the programs that we are doing.

Dr. Wiesner has held the office open at night, we do services in EPSD programs in schools, everything, and still there is a hard-to-reach population which has a lot to do now with our issue around maternal substance abuse, cultural differences, and those things that we have to find a new way to reach that hard-to-reach woman because it is her baby that is dying in this State.

Senator **Fowler**. Thank you.

Dr. Floyd, let me ask you one other question before we leave it. Georgia is home to the Federal leading health prevention agency here in our State. You did spend a little time in your testimony talking about how you need help in getting rid of some of this redtape. Of course we hear about that in any of our public and private endeavors when we are dealing with government, but I wish you would tell me how specifically, with CDC right here, how you coordinate the State agency with these programs, and in your estimation what can we do either at the State or the Federal level to cut down on some of the redtape and improve that coordination.

Dr. **Floyd**. Actually, Georgia is kind of lucky sitting in the back yard of CDC. We work quite well on a lot of joint projects. It really is not the CDC redtape, it is the USDA, it is the HCFA redtape that I am much more concerned with than the issues around CDC.

I need to be able to get Ms. Jones on the Medicaid program without swearing on a stack of Bibles that she has no cemetery plot, that her great-great grandmother was not an alien, and so forth and so on. We are working on that.

Dr. Sullivan is trying to get a uniform one-page application for everyone. My goal is to have a one-page, one-side application for Mrs. Jones and all of her children to get on Medicaid, AFDC and WIC and fell swoop, and I want it at the Kroger checkout counter. [Laughter.]

But in reality, even with this application which we have in Georgia—we have devised this application—Ms. Jones who is pregnant in terms of HCFA is a family of two, in terms of USDA is a family of one. I have to figure out her resources in one and not in the other. It is really Federal regulations. If we could just get the folks at the top to say this is the definition of Ms. Jones in a family. Give me the definition, I will work with it, but just give me one.

That list just goes on and on and on, so we are working on the issue of one-stop shopping, uniform eligibility of all programs. In fact, if you are Medicaid eligible you should automatically be WIC eligible in this country, and those kinds of things, and we have turned in this list to the Secretary. They are working on it, so they say.

Senator **Fowler**. Fantastic. [Laughter.]

Well, if we ever, ever again have a Democratic President, which is probably doubtful, we will make you the Secretary of HHS, Dr. Floyd. [Laughter and applause.]

Ms. Chamness, I am sure your testimony had the effect on everyone that it did on me. It seems to me your work defines what service ought to be.

You passed quickly, probably only by the time constraints, but did you not mention how private efforts are involved in your work of caring for children with AIDS. How do we do that? Is there any good news? Have you been able to attract private resources and private funds? Obviously that would be a remarkable step if we could match, even begin to match, the public efforts with private efforts in dealing with this tragedy.

Ms. **Chamness**. We feel very fortunate in the sense that we have been able to attract those people in the private sector. As Dr. Roper stated earlier, I think we are hindered by our inability to articulate often what the needs are and what can be done.

I would like to share with you one of the things that has been mentioned by a number of people this morning. We, because of our calls about the hungry children, determined that we needed to introduce these children to good nutrition early on, because the children who are in our residential programs who are with foster parents, are absolutely healthy children. They are healthy in every way except for the fact they are battling this awful virus.

As we started our research on doing a baby's Meals on Wheels we, of course, went to our public sector, how can we cooperate with the WIC program in order to have this happen. Second, how can we get it underwritten from the private sector, and then, last, what about the volunteers, so it is a classic example of partnership on all fronts.

The other thing that we believe is because we make the commitment first, and we have through our organization made the commitment that no child will live unnecessarily in the hospital in Georgia. The commitment has come first, and we have discovered that often people will follow and give us the money to do once they see the commitment is there, so that has been very powerful for us.

We are dedicating this week our house in Savannah, we are dedicating the first specialized day care, also this week, in DeKalb County.

Dr. Thacker was talking about day care, and I am so pleased about the lead that CDC has taken with day care. We believe these children should be mainstreamed; however, there are unique problems such as the infection and the risk of infection, so we have said, "OK, we have got to start to take care of these children in day care," because currently there are very few, if any, day care in Georgia that will accept the children with HIV, so we have started a day care where we will make sure all of their nutritional needs are met, we will monitor their health needs, we will take care of their psychosocial developmental needs, and we are doing this with private funds altogether.

In each instance we have attempted to identify a very real need, and then we have said, "OK, we will do the pilot program hoping that we can show that it is cost effective and, of course, always that it is the humane thing to do," and then we will open up doors for Federal funds, for public funds.

The other one that is my major cry right now that we will need a tremendous amount of money for, and I think that much of this money will have to come from the Federal Government, is to make sure that there is some place for the mothers to feel that they have a safe place for their children when they are sick.

We get so many calls about mothers that want to be in drug treatment, they do not want to give up their children, but they feel that they do not have an alternative, so we have said, "Yes, we will take care of your children," but we simply do not know how we are going to do that yet.

Senator FOWLER. That report certainly encourages me. You know, we fund, and foundations fund a lot of pilot programs through private money to demonstrate a public problem.

Ms. CHAMNESS. That is exactly what we are doing.

Senator **Fowler**. It would be extraordinary if we could somehow, through our public research where we have identified public problems, attract the private capital to help deal with that need.

Thank you for your work.

Ms. **Chamness**. Thank you.

Senator **Fowler**. Dr. Wiesner, I have sort of saved you for last deliberately. I do not feel like I can quite get away with asking Dr. Thacker or Dr. Roper this, but I was disturbed. We had an Institute of Medicine recent report that concluded, and I quote, that "America's public health system is in disarray."

What does that statement mean to you as the director of a large county health agency, and if you agree with that statement, I would like for you to react to that statement, and depending on your reaction tell me what steps we should be doing in the Federal and State government to shore up our public health system.

Dr. **Wiesner**. Senator Fowler, I think society is in disarray, and for that reason I think there is some substantial disarray in the public health system, but I do not agree with the report in the sense of isolating that characterization just to public health.

We have a crisis in lack of commitment to investing in our people up front, and that is reflected not only in the public health system but in the school systems, in the private industry's development of people for training to carry out skills.

Now, at the same time when we say the public health system is in disarray, that same report identified the fact that public health has made enormous contributions to the health of people in this country.

Senator **Fowler**. Absolutely.

Dr. **Wiesner**. There are literally thousands of dedicated public health workers throughout this country.

I actually thought for a moment before we came to this hearing to ask all 109 of our public health nurses to be there in the back of this room and stand up, because those are the folks that are characteristic of some of the folks that do this wonderful work.

Now, at the same time we spoke earlier about a diagnosis of the problem with the system, and I did have opportunity here at CDC to give a seminar and to offer four diseases of the public health system that I think need to be addressed.

The first is hardening of the categories. People do not come as little packages of problems, they come as whole people. Now, I think having a disease and a problem to focus on is particularly important, particularly from the point of view of the Senate and the Congress in the sense that that is the only way that the American people can decide they are going to do something about a problem is to label it with a problem, so for the acquisition of resources—and I would not recommend stopping the acquisition of resources for public health—the categorical approach is particularly important, but for the delivery of services they must be integrated in ways that people can understand it, and we are trying to do that in the DeKalb Board of Health.

I referred to the private industry's problems. We share those. American industry has not invested in training, and the second disease of the public health system I would call the hypo-commitment to training. Examine the training budgets of the public health agencies in the U.S. Public Health Service, and how many are focused on training people to carry out those core functions of community health assessment, citizen-based policy development, and true assurance that needs are met, and we need to start investing in the training of this work force because it is an extremely powerful work force, it just needs to be given the skills and the resources to work.

The fourth disease of the public health system I would characterize as cultural incompetence. We are working at the DeKalb Board of Health to improve our abilities, not only to have representation from minorities on our programs, and not only to hire people according to their abilities and provide people of African-American, Asian, and Hispanic backgrounds opportunities to work in the public health system, and not only for them to advise us on how to develop a program, but most importantly for them to develop the program themselves, to actually involve them in the ownership and delivery of that program from the beginning.

The public health system from our level to the CDC to the Federal level and within the States needs to work on its cultural competence.

Last—you have referred to this in the opening remarks of this hearing—the concern about insufficient insurance to pay for medical care. Often times we need to educate the public to let them know that often they are speaking of illness treatment care and not truly community-based, prevention-oriented primary health care services, and there has developed the fourth disease of the public health system and that is the tension headache between prevention and treatment.

We are going to work at DeKalb County Board of Health to integrate these efforts. We have a critical shortage in primary health care services. Mr. Bob Johnson, the administrator of Grady, was here earlier and I wish he were here now because without Grady the DeKalb County Board of Health would go under. They provide enormous primary health care services.

Senator FOWLER. They provide about three-quarters of our county health system.

It is amazing, but they are interested, and we are interested in decentralizing the prenatal services, getting these prevention and early intervention services accessible to people in our county, and not aggregating them in major institutions that are often driven by maintenance of the institution and the technology, and we are very proud of his leadership in moving Grady services out into the county.

The debate on health care has not been what it should have been a discussion of. It should be a discussion of improving people's health, not who profits and who pays from illness treatment delivery.

I think there is a disarray in public health, but it is improving. The Nation has stated its goals, this healthy communities document has come out that will describe how we can actually construct our specific community objectives so that they can be consonant with national goals, and I mentioned earlier the APEX/PH project that tells you how do you get from here to there, what is the process of developing these interventions and defining what needs to be done at the community, and the first part of that we need training and support, not only for the prevention programs that I specifically outlined, but for some of Dr. Roper's initiatives in building and improving and modernizing the infrastructure of public health.

Thank you for that question. [Laughter.]

I am glad we do not have any filibuster rule. [Laughter.]

I thank all of the panel for not only the excellence of their testimony, but its specificity which will be very helpful. If we have not learned, if I have not learned anything else, and I hope the word will go forth from all five of these experts simply we are going to spend the public's money at one end or the other. We are either going to spend it more for training and education of our preschoolers and elementary schoolers, we will spend it on prenatal care, we are going to spend it on developing ways to minimize these trends toward violence and abuse, or you are going to spend it in more hospitals, more jails, more police, more welfare at the other end.

That seems to me the great lesson of prevention and where we could cut off many of society's problems and the disarray as Dr. Wiesner said of society that is reflected in our needs in public health.

Thank all of you very, very much. We will take about a 5-minute break, then we will have our next panel. [Applause.]

[A brief recess was taken.]

STATEMENTS OF:

DR. ELIZABETH CONNELL, PROFESSOR OF GYNECOLOGY AND OBSTETRICS, EMORY SCHOOL OF MEDICINE

ERMINIA MCINTYRE, INSTRUCTOR, PACE ACADEMY, ATLANTA, GA

WILLIAM WHITE, COORDINATOR, HUMAN SERVICES FACILITIES, DEKALB COUNTY, GA

DR. GLORIA CLAYTON, PROFESSOR OF NURSING, MEDICAL COLLEGE OF GEORGIA

VIRGINIA BALES, DEPUTY DIRECTOR, CDC CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

INTRODUCTION OF PANEL 2

Senator FOWLER. Our second panel this morning will address prevention strategies for women's health, and we are going to begin with the serious topic of breast and cervical cancer. We will hear first from Dr. Elizabeth Connell, professor of gynecology and obstetrics at the Emory School of Medicine, and Mrs. Ermi McIntyre, an instructor at Atlanta's Pace Academy, who has dealt personally with breast cancer.

Next, William White, the human services facilities coordinator with DeKalb County. I expect to speak on the special challenges facing low-income women as they attempt to build good health habits. Mr. White, a friend of mine for a long time, I know has participated in a community health assessment and promotion project sponsored by both the CDC and Emory, probably the only male in the group.

Then we will hear from Dr. Gloria Clayton, professor of nursing at the Medical College of Georgia, to discuss prevention issues of concern to women in their later years. Glad to have you, Dr. Clayton.

Finally, Virginia Bales, the Deputy Director of CDC's Center for Chronic Disease Prevention and Health Promotion, will comment and react to the agency's initiatives in women's health.

I am delighted to have again such an experienced and informed panel. Dr. Connell, we will begin with you.

STATEMENT OF ELIZABETH CONNELL, M.D.

Dr. CONNELL. Thank you very much. It is a privilege to be here.

By way of background, I would like simply to point out that I spent 5 years in rural Maine in a huge metropolis of about 900 and some souls, then spent about 20 years in New York City developing family planning clinics and doing ob and sexually transmitted diseases [STD] work in Spanish Harlem, Morningside Heights thereafter, so I have had a lot of opportunity through these years to see how much we can do if we have good preventive health measures, and very sadly I have seen what happens when we do not, so I think these are very, very key issues, particularly to the reproductive health care of women.

Now, unfortunately thousands of American women die needlessly every year from these two diseases, breast and cervical cancer. The sad part is that the majority of these deaths could have been prevented. We now have good medical techniques that allow us to diagnose both of these diseases very early, and at a time when we have an awfully good chance of curing all of these women.

First, I was asked to look at the issue of breast cancer. If you look at incidence, you find it has gone from 85 per 100,000 in 1980 up to 112 per 100,000 in 1987, and this is an unfortunate increase of 32 percent.

The American Cancer Society estimates now the numbers are coming down, but one in every nine women in this country will get breast cancer. There will probably be 175,000 new cases in 1991, and 44.5 thousand women are going to die of this disease. If we look strictly at Georgia, we will find probably about 4,200 new cases in 1991 and 1,100 deaths.

Now, actually when you look at the cause of these cases, you find that almost 20 percent of these are due to the fact that women are not having mammograms. It is shocking to me as a doctor that 60 percent of American women over 40 have never even had a single screening mammography for breast cancer. I think that is a very, very disturbing statistic.

We know now the majority of the cancers could be detected when they are quite small. We teach women to examine their breasts, but we do know that with mammography we can pick up these lesions very early, months actually before the women can find them themselves.

Our failure to provide adequate consumer education, screening services, and appropriate treatment, all of these I think if you put them together these must all be blamed for this really very unfortunate series of statistics which are not actually improving all that much.

I was also asked to look at the current situation with cancer of the cervix, and here I think the morbidity and mortality is even more reprehensible. Even though in this disease we have had an overall lowering of the incidence, the rate of lowering unfortunately has slowed down considerably.

Again, the American Cancer Society's recent estimates show 13,000 new cases in 1991. Last year, 130 women died of this disease in Georgia, and probably there will be at least 4 to 5,000 deaths this year in the United States.

Now, the reason this is particularly bad is that with good screening we should not have any of these problems. After Papanicolaou developed his smear test we could detect these early changes in the cervix easily and accurately, and we really had lots of time, we had months and even years between these early changes and the development of cancer, and, therefore, I believe that cancer of the cervix should now be as extinct as the dinosaur.

Unfortunately it is not, and the reasons again here are inadequate screening, treatment, inadequate follow-up, and this is particularly true for Afro-American women in the United States.

Now, the flip side of this, I think, is also very instructive. It does show that when you apply what you know and what you can do you can begin to get rid of a major killer of American women, and we have seen this certainly with cancer of the cervix. The tragedy is that it continues because we are not dealing with it properly.

As a doctor in many different situations, I have always found it very sad to see disease and death. It is unfortunate thing, and it is particularly sad when you are dealing with conditions that could have been prevented.

There is untold suffering and pain and misery from these diseases that we see in women, but much broader than that the impact of these diseases on their families, on the health care system as a whole, society as a whole. I think all of these deserve a lot more attention perhaps than we have given to them.

PREPARED STATEMENT

We all know I think now that good public health preventative measures not only reduce pain and suffering, but clearly reduce health care costs. The cost of delayed diagnosis, failures of treatment, extensive hospitalizations, and death are very, very high, and the two issues I have been asked to address, cancer of the breast and cancer of the cervix, both major killers and maimers of women, is particularly sad because we ought to be preventing these situations.

I personally am very grateful to see that you are giving visibility to this problem, and I would certainly hope that you would continue your endeavors to find solutions to these preventable and unfortunately not extinct diseases.

Thank you very much.

Senator **FOWLER**. Thank you very much, Dr. Connell.

[The statement follows:]

STATEMENT OF DR. ELIZABETH B. CONNELL

Thousands of American women continue to die needlessly each year, victims of breast and cervical cancer. The majority of these deaths could have been prevented, since we now have techniques that will allow us to diagnose both diseases very early, when the chance of complete cure is within our grasp.

The incidence of breast cancer has increased from 85 per 100,000 in 1980 to 112 per 100,000 in 1987, a 32 percent increase. The American Cancer Society (ACS) estimates that one in nine women will get this disease, and that 175,000 new cases will be diagnosed in 1991, and 44,500 women will die. In the state of Georgia, 4,200 new cases will occur in 1991 and 1,100 women will die. Much of the mortality, 19 percent, can be ascribed to non-use of mammography, more than 60 percent of U.S. women over 40 never having been screened. Inasmuch as mammography could have detected the majority of these lesions when they were quite small, many months before the women could feel them, our failure to provide adequate consumer education, screening services and appropriate treatment must be blamed for this most unfortunate series of statistics.

The situation with cancer of the cervix is even more reprehensible. Even though the overall incidence has decreased in recent years, the rate of decrease has slowed down, and ACS estimates that 13,000 new cases will be diagnosed in 1991. In fact, 130 women died of this disease in Georgia in 1990, and 4,500 deaths will occur in the U.S. in 1991. With proper screening, virtually none of these cases would have occurred. With the advent of the Papanicolaou smear test, it became possible to detect changes in the cervix many years before cancer actually developed. Thus, cancer of the cervix should now be as extinct as the dinosaur. Unfortunately, it is not, because of inadequate screening, treatment and follow-up, particularly among Black women. However, the decline incidence does show what can be accomplished when early detection and therapy can do to lower the risk of a disease.

It is always sad to see disease and death; it is particularly sad when they could have been prevented. In addition to the totally unnecessary pain and suffering these conditions inflict on women, their impact on families, the health care system and society as a whole must be carefully considered. It is a well established public health dictum that early diagnosis and treatment significantly reduces the health care costs that inevitably arise from late diagnosis, failed treatment, prolonged hospitalizations and death.

STATEMENT OF ERMINIA MCINTYRE

Senator Fowler. Next we have Mrs. McIntyre who is here to relate personal experiences. Thank you, Mrs. McIntyre.

Mrs. McIntyre. Thank you, Senator Fowler.

I am one of the statistics. In the summer of 1986 I had my first mammogram, and that is when I discovered that I had breast cancer. Even though I had been fairly regular about self-exam and had a gynecological checkup every year I was almost 41 years old before I had that first mammogram.

I had moved away from my regular doctor and was going to a doctor I did not know very well and one who did not know me very well. For 2 years in a row I asked him if I should have a mammogram as part of my regular yearly checkup. Since neither he nor I had felt any lumps and I was in none of the high-risk categories there seemed no real reason to have a mammogram, but that summer just before my birthday I received a phone call from one of my best friends and she threatened not to send me my birthday present if I did not have a mammogram. She always sent wonderful presents, so I think that——

Senator Fowler. That is a good private initiative that I think we ought to encourage. [Laughter.]

Mrs. McIntyre. That year she gave me my life, because the tumor which was discovered was a mere 1 centimeter, but it was an aggressive tumor and I had seven lymph nodes with cancer cells. I am certain that if I had waited until the lump was discovered by self-exam I would not be alive today.

There are many more TV and newspaper ads urging women to have mammograms, but I think so much more needs to be done. Women have to be taught to be forceful about demanding from doctors who do not yet recommend base line mammogram between the ages of 35 and 40, and doctors have to be convinced that a mammogram should be a standard part of a woman's checkup.

Finally, we have to make the whole procedure more affordable to women in all financial categories. Many women have told me that their insurance coverage does not cover diagnostic mammograms, and the cost of over $100 puts these tests out of the financial reach of many women. There are many things that can be done by Government and State and business to help women in this particular group.

In the almost 5 years since I was diagnosed with cancer, I have undergone a lumpectomy and radiation, a year of chemotherapy, and a mastectomy when the cancer recurred in the same breast 2 years ago. I have also had reconstructive surgery, and more surgery this year for another local recurrence.

These have been 5 very difficult years for me and my family, but in some ways they have been 5 of the best and most productive years of my life. I have been there to see my children grow, I have gone to little league games, I have sewed on Boy Scout patches, and I have been able to work. Except for 2 months following my surgery, I have been able to teach my students every single day of the last 5 years. My teaching is very important to me. It not only helps me support my family, but it gives me the knowledge that I am contributing to the future of our society.

In many ways my story is one of the ideal ones, because I had enormous loving support of family and friends and employers; I had people trying to make life easy for me while I was going through treatment.

Finally, I was lucky enough to have insurance coverage for a good part of my treatment. One of the biggest worries I have is the amount of my family's income which is spent on my treatment. Even with insurance, the out-of-pocket expense is enormous. The continual paperwork is time and energy consuming, and the wait for reimbursement is often frustrating. My husband spends a great deal of some week ends on nothing but insurance paperwork.

When my husband changed jobs in the middle of my treatment my oncologist was much more concerned whether I would be covered under new medical insurance than that I would be able to receive good medical care. He told me that some of his patients never again were able to receive insurance coverage.

Many women are not so fortunate as I am. They go through the physical and psychological and financial trauma all alone; they are raising their children all alone; they do not know where to go for the best treatment; they do not have doctors who make them a part of their medical care; they either do not have medical insurance or live in fear that they will lose the coverage if they cannot work. Many cancer patients stay on jobs longer than they have to, jobs that are no longer creative or no longer pay well, because they need the insurance coverage.

When I was diagnosed with breast cancer 5 years ago, the statistics that were quoted to me were 1 in 11 women. Today the statistics are one in nine women will develop breast cancer.

The combined screening of breast exam and mammogram is our best method of early diagnosis, and early diagnosis with immediate and appropriate treatment means prolonged and productive life.

When I was first diagnosed with cancer, the first two people that my husband and I told were our sons. We told them as optimistically and as truthfully as we could. My younger son who was 6 years old at the time looked straight into my eyes and the first thing he said was, "You are not going to die, are you?" I answered as honestly as I possibly could and said, "I am going to try very hard not to die." So far I have been able to keep that promise.

Women need the combined and cooperative efforts of the Federal and State government and other public and private organizations for research into causes and possible prevention, new and better methods for treatment, and agreement on the proper methods of treatment for different kinds of breast cancer.

PREPARED STATEMENT

Perhaps even more important for the immediate future, we need a real united effort for early detection and intervention for all women. Early detection means prolonged and saved lives, it helps women to keep their jobs and support their families and be constructive members of our society, and we need simplified and accessible methods of funding so that all women whatever their socioeconomic status might have access to early diagnosis and treatment.

In these ways, Senator, we can help more women make good on their promises.

[The statement follows:]

STATEMENT OF ERMINIA MCINTYRE

My name is Erminia McIntyre. I live in Atlanta. I am here to present some of my personal experience with breast cancer.

In the summer of 1986, I had my first mammogram. That is when I discovered that I had breast cancer. Although I had been fairly regular about self-exam and although I had had a gynecological check-up every year, I was almost 41 years old when I had my first mammogram. I had moved across country and was going to a doctor whom I did not know very well. For two years in a row I had asked my new doctor if I should have a mammogram as part of my regular yearly check-up. Since neither he nor I had felt any lumps and since I was not in any of the high risk categories, there seemed no real reason to have the mammogram.

That year, however, just before my exam (which happened to be close to my birthday) I received a call from a close friend in Atlanta. She asked me what I wanted her to send me for my birthday, and then told me that she had had her first mammogram. When I told her that my doctor had not yet recommended one for me, she insisted that I get one. She threatened not to send me a birthday gift if I did not have a mammogram first. I really can say that I owe her my life. The tumor which was discovered by that first mammogram was a mere one centimeter in size, but it was an aggressive tumor, and on further examination, it was discovered that seven lymph nodes had cancer cells in them. In my own mind, I am almost certain that if I had waited until the lump was discovered by self-exam, I would not be alive today.

I am pleased to see the number of TV and newspaper information ads which now urge women to have mammograms and check-ups. There were not nearly so many five years ago. Still, more can be done to take the fear out of going for that first mammogram. And women have to be taught to be forceful about demanding from doctors who don't yet recommend a base-line mammogram between the ages of 35 to 40 years. And doctors must be convinced that a mammogram should be a standard part of a woman's check-up.

We must make the whole procedure more affordable to women in all financial categories. Some women have told me that their insurance does not cover diagnostic mammograms, and the cost of $100 or more puts these tests out of the financial reach of many women.

There are many things that can be done by government and business to help women in this group. For instance, in my own school, as part of a commitment to wellness, the faculty and staff were offered a Saturday medical exam. As part of that exam, a mobile mammogram unit was brought right to school from one of the local hospitals. This unit is available to businesses by just making a reservation. The cost of these mammograms was only $50 to each woman, about half the cost. (By the way, as a result of this screening three of our teachers were sent to doctors for further diagnosis.) The mobile unit staff provided not only breast cancer screening, but also showed a film and taught proper methods of self-exam. One of our staff told me that it was the best lesson she had ever received on breast self-exam. I know that for a large number of women, even $50 is too much cost.

In the almost five years since I was diagnosed with cancer, I have undergone a lumpectomy and radiation, a year of chemotherapy and a mastectomy when the cancer recurred in the same breast two years ago. I also had reconstructive surgery and more surgery this year for another recurrence. These have been five difficult years for me and my family, but in many ways they have also been five of the best years of my life. I've been able to watch my children grow. I've been to countless Little League games and I've sewed on who knows how many Boy Scout patches and gone to who knows how many covered dish banquets. And (except for two months following my surgery) I have been able to teach my students every single day of the school year. My teaching is very important to me. It helps me support my family and it gives me the knowledge that I am contributing to the future of our society.

In many ways, my story is one of the "ideal" ones. I tolerated treatment well. I have been surrounded by a loving and supportive husband, an entire support systems of friends who cooked for me, did carpool, gave my children fun weekends while I was on chemotherapy. I worked in schools where everyone from the administration down tried to lessen my teaching and extracurricular load, and I was still paid full salary. I have had access to the best in medical treatment and to caring doctors. I've read a lot about breast cancer and ask continual questions of my doctors. I am a real part of the decision making process in my medical care. And finally, I was lucky enough to have insurance coverage for a good part of my treatment. One of my biggest worries is the amount of my family's income which is spent on my treatment. Even with insurance, the out-of-pocket expense is enormous; the continual paper-work is time and energy consuming and the wait for reimbursement is often frustrating. My husband often spends a great part of weekends on insurance papervork. When my husband changed jobs in the middle of my treatment, my oncologist was much more concerned whether I would be covered under our new medical insurance than that I would be able to receive good medical care. He told me that some of his patients never again were able to receive insurance coverage. (In our society, where people change jobs so frequently, this is an enormous burden on someone who has cancer.)

Many women are not nearly so fortunate. They go through the physical and psychological trauma alone. They are raising their children alone at the same time they are being treated for cancer. They don't know where to go for the best treatment. They either don't have medical insurance or live in fear that they will lose the insurance coverage if they cannot work. Many cancer patients stay on in jobs that are no longer creative or no longer pay well because they need the insurance coverage.

When I was diagnosed with breast cancer five years ago, the statistics that were quoted to me were that one in eleven women would develop breast cancer. Today, less than five years later, the statistics now state that one in nine women will develop breast cancer. The combined screening of breast exam and mammogram is our best method of early diagnosis. And early diagnosis with immediate and appropriate treatment means prolonged and productive life.

When I was first diagnosed with cancer, as soon as my husband and I had returned from conferring with the oncologist about my treatment, the first people we sat down with were our two children. We have always tried to put things in an optimistic light, but have always tried to be truthful and to speak plainly. We told them that I had a cancerous tumor in my breast and that I would need some special medicines and treatment and that sometimes I might be tired or even feel sick. My younger son, who was six years old at the time, looked straight into my eyes and the first thing he said to me was, "You're not going to die, are you?" I replied as honestly as possible and said, "I'm going to try very hard not to die." I think that is what most women who have or have had cancer would say. So far, I've been able to make good on that promise.

Women need the combined and cooperative efforts of the federal government and other public and private organizations for research into causes and perhaps prevention, new and better methods for treatment, and agreement on the proper methods of treatment for different kinds of breast cancer. Perhaps even more important for the immediate future, we need a real united effort for early detection and intervention for all women. Early detection prolongs and saves lives. It helps women to keep their jobs and support their families and be constructive members of our society.

And we need simplified and accessible methods of funding so that all women (whatever their socio-economic status) might have access to early diagnosis and treatment.

In these ways, we can help more women make good on their promises.

CANCER INCREASE

Senator FOWLER. Thank you so much, Mrs. McIntyre. [Applause.]

I know that as a teacher you have already influenced many young lives. Thank you for that public service.

Mr. White will forgive me, I think it may be helpful to follow up with these two witnesses just before we go on.

Dr. Connell, with that alarming statistic of a 32-percent increase in breast and cervical cancer since 1985, what are the factors which you feel are preventing women from being screened?

Dr. CONNELL. I think, unfortunately, they are multiple, there is no single answer. I think education is important. I think many women simply are not aware of the fact that this disease is that common, they are not aware of the fact that it can be diagnosed very early on when the chances for cure are great.

I think some unfortunately in the health care service professions are lacking in the importance of the perception of public health. You know, in medical schools we still treat people much more than prevent disease. I think this has been a common thread through all of medical training, and we have not moved as quickly or as effectively toward the concept of prevention. Doctors still treat disease, they do not prevent disease, and so I think medical education has a certain amount to share as far as blame is concerned.

I think the——

Senator FOWLER. If you will forgive me for interrupting you——

Dr. CONNELL. Sure.

Senator FOWLER. How much of the problem in your experience, again on the screening—you say 60 percent of women over 40 have never had a mammogram—how much of that, and we will hear some more I am sure from the CDC, is a problem of access?

Dr. CONNELL. I think a lot of it is. Women do not have either the ability or the finances to avail themselves of what we know they need. I have never worked anywhere in the world that when services of this nature were not properly funded, offered in a sympathetic, empathetic fashion with staff who are tuned in to this sort of health care, I have never seen anywhere that women will not come in very happily in most cases and accept the good public health care that we offer, so it is matter of who offers it, how it is offered, the perception of women in terms of the need of doing these things. I think all of these go together dealing not only with the professional groups, but certainly consumer people, consumer advocates to join hands, and I find this worked very well in addressing these major public health problems.

I think in all of these areas we are not doing anywhere near as well as we could do—financially, socially, professionally—all of these need to be accelerated if we are ever to come to grips with this one in nine which has gone down from 12 to 11 to 10 to 9, and presumably unless we find a reason for these cases we will continue to see this number get worse.

Senator FOWLER. Mrs. McIntyre, based on all you have gone through in the last 5 years with your experiences, what have you concluded—it would be very helpful from someone with your experience in coming through all the treatment—how have you concluded is the best way or approach to counsel young women on what they need to do and when they need to do it?

Mrs. MCINTYRE. I talk with my students, especially my girls, that they have to be very forceful about their own health. I was brought up to be very docile and to obey authority, and if the doctor said I did not need a test, well, I did not need it.

I think we know differently now, and I think we need to be personally and politically active. I think for many women it is really asking them a lot to take time off of work to take a test which they cannot afford when they have no symptoms, and I think we have to make it easier by more education and more accessibility, and take the worry of the financial burden of that early screening off them, because their lives will be saved.

Senator FOWLER. You know, depending on where you go and who you want to listen to, you can get every kind of statistic on instances of cancer. We have spent billions and billions of dollars of the public money through the National Institutes of Health, cancer societies, trying to find this elusive cure. I have my own statistics because I have been interested in this problem for so many years, and that is that in 1960 one out of six people got some form of cancer, and one in five died. Now in 1990, one out of five gets some form of cancer, and one in four dies.

Though medical technology and expertise has made remarkable progress with some cancers in some parts of the body, others are still totally out of control. But the one underlying message that comes through is if you diagnose and catch it early enough, it need not be fatal. But we have not put our efforts, our public efforts, or our private efforts for that matter as Dr. Connell just said as a physician and through the medical schools and the training of our physicians there simply has not been that emphasis.

Please.

Dr. CONNELL. I think it is important that we continue to conduct studies. Certainly that gives us an idea of incidence and trends and these things, but having worked in these areas for many, many years I am more upset by the fact that we have lots of studies that show how to cure problems, and yet we are not acting on those studies. We keep studying something that we understand, and yet we do not utilize what we have learned to move ahead and carry out the public health measures that we have proven over and over and over again will work, and to me there is a dichotomy of rationality in these two situations, and, I think, probably that is what you are trying to address, because we know how to deal with a lot of these, but we do an absolutely crummy job in attempting to deal with them.

Senator FOWLER. Absolutely.

Well, I thank you both.

STATEMENT OF WILLIAM T. WHITE, III

Next, William White, human services facilities coordinator with DeKalb County. Glad to see you, Mr. White.

Mr. WHITE. Good morning, Senator Fowler.

I have come this morning to deliver testimony regarding CHAPP, the Community Health Assessment and Promotion Project, which enables a segment of our population, adult Afro-American women, to lead more healthy lives.

I served as an executive committee member of the Community Advisory Council, as well as a participant.

I believe a picture is worth a thousand words, so I have a prepared 2-minute video for your review, and I have also had the opportunity to do something I always wanted to do, which is to say "Roll tape!" [Laughter.]

[A videotape presentation was made.]

Senator FOWLER. You did a pretty good job exercising with all those women. [Laughter.]

Mr. WHITE. I enjoyed it. [Laughter.]

Senator FOWLER. It is like the Cunard Lines, half the fun is getting there.

Mr. WHITE. Yes. [Laughter.]

CHAPP was developed by the Centers for Disease Control and Emory University. It was designed as one of the first projects addressing weight reduction in urban, obese Afro-American women, and to reduce the high incidence of cardiovascular risk factors among this population between the ages of 18 and 59 living in Kirkwood, a predominately low-income black community in southeast Atlanta.

Members of this population were screened and assessed at a community-based health clinic. Those eligible were referred to our 10-week design intervention, which included exercise and nutrition components, special interest workshops, and seminars. The program had a high retention rate due to the following factors: Community ownership of the project; project activities being held in community-based facilities; participant input into ongoing program modifications; followup calls and in-person contacts made by project staff to participants; and the incorporation of door prizes and incentives.

The CHAPP program was evaluated by CDC. That evaluation indicated high participation and completion rates, a significant statistical reduction in weight loss and blood pressures both immediately after the intervention and follow-up consultations conducted 4 months later of the 400 participants referred to the program.

Other results included changed eating habits, better understanding of nutritional factors, and increased self-esteem.

CHAPP received the national Award for Excellence by a community prevention promotion project from the Secretary of Health and Human Services in 1988. Papers were presented on CHAPP at the request of numerous public health conferences, both nationally and internationally, including conferences held in Australia and England.

To facilitate replication of our project, a step-by-step how-to manual with an accompanying video and cookbook was produced.

What happened to the project? The project was originally funded as a demonstration project for 1 year by CDC. Because of its success, it was funded a second year. In our third year, the Kaiser Foundation provided funds, but at a severely reduced level. The funding was not sufficient to allow our community-based advisory council to meet its goal of evolving into a nonprofit organization which could support the project and continue to assist in eradicating the cardiovascular high-risk factors among obese African-American women, thus prolonging their lives and contributions to our community.

PREPARED STATEMENT

This type of prevention model requires more time, energy, commitment, and investment than a clinical one, but it is well worth the effort as a cost-effective, efficient prevention and intervention model rather than a more costly crisis intervention strategy.

[The statement follows:]

STATEMENT OF WILLIAM T. WHITE, III

The disparity between benefits and services received by the U.S. population in general and those received by minorities, particularly Blacks, is not a new topic of investigation. Health issues are no exception as documented by The Report of the Secretary of Health and Human Services' Task Force on Black and Minority Health.

Not surprisingly, the higher excess mortality rates among Blacks as compared to whites are accompanied by a greater prevalence of preventable or modifiable health risk factors such as hypertension, cigarette smoking, diabetes and obesity leading to cardiovascular disease and stroke. Among middle-aged Black women, diabetes and obesity were most prevalent in this community.

The Community Health Assessment and Promotion Project (CHAPP) was created and developed through a cooperative agreement between the Emory University Department of Community Health and the Centers for Disease Control. The Project's first step included the formation of a community coalition which consisted of an alliance of residents, community leaders and neighborhood based health and human service professionals and representatives from the Centers for Disease Control and Emory University. The targeted community was a predominantly Black, low socioeconomic, urban community known as Kirkwood.

The members of the Coalition participated in all aspects and phases of the project including defining the community's perception of its most pressing problems through an 1,800 sample community opinion poll, and determining the prevalence of health risk factors among its 86,000 residents through a separate 1,200 sample survey. The greatest personal concerns of the 1,800 polled were money and health. A closer look revealed that 42 percent of the persons older than 50 years and 47 percent of persons 65 years or older perceived their health to be "fair" or "poor". The results of a separate survey of health risk factors among a sample of 1,200 persons in the community indicated that the prevalence of uncontrolled hypertension was double that reported by the State. Nearly 63 percent of the interviewees indicated a sedentary lifestyle. About 28 percent were overweight and more than 31 percent smoked cigarettes. The prevalences of these risk factors were all higher in this community than those for the State of Georgia.

In the summer of 1986, the CHAPP Coalition selected cardiovascular disease as the priority health problem for their community and specifically targeted minority females. They designed a nutrition-exercise intervention program, functioning out of a community health clinic. The program used facilities at a clinic, a YMCA, and a school, all of which were within close walking distance of each other and in an easily accessible area of the community. Persons who were clinically diagnosed as obese and between the ages of 18 and 59 were recruited for the program.

Prospective participants were screened at a local clinic. This process included a short physical examination, a body fat determination, a step test to assess cardiovascular condition, and the completion of a questionnaire. The questionnaire addressed health risks, occupational history, current exercise activities, reasons for wanting to increase physical activity, knowledge of the effects of regular activity and three social support structure. Weekly weight and blood pressure records were maintained. These measures were also collected 3 months after the intervention. Attendance records were kept and those persons who stopped attending were given an exit interview over the telephone.

The program was comprised of a ten week cycle of exercise classes, supported by meetings of the nutrition/healthful living component. The Community decided that these activities should be held every Tuesday and Thursday from 6 p.m. to 8 p.m. to maximize attendance. On Tuesday, the nutrition component of the program was conducted during the first hour and the exercise component in the second hour. The first hour on Thursday was used for assessment, counseling, and special interest sessions. This was followed by an hour of exercise by the participants. At this time, participants were recognized and rewarded for their accomplishments.

The nutrition component initially consisted of a 1-hour lecture but was changed to short presentations followed by food sampling sessions at the suggestions of the participants. These sessions usually lasted 30 minutes and consisted of demonstrations of healthful cooking techniques and recipe sharing which eventually resulted in a CHAPP cookbook.

The exercise component of the program consisted cf water aerobics, low-impact aerobic dance and walking. Participants could enroll in two of these three programs. The low-impact aerobic dance program consisted of a warm-up period designed to stretch the major muscle groups, an aerobic workout, and a cooldown period of slower movements and relaxation. The water exercise program, which was easier for extremely overweight persons, was similar to the low impact aerobic dance program—a warm-up period followed by aerobic exercises and cooldown period. The special interest sessions were used as a time of assessment and presentations dealing with such topics as nutrition, injury and stress control, dancing for the elderly, lower back pain, physical therapy, etc.

Some of the reasons that the project was successful include: input being solicited from an advisory group of respected community residents, leader and health professionals to assist in project development prior to its formal presentation to the community; community residents being hired for project related jobs; project activities being conducted in community-based facilities; community generated opinion poll and a survey of health risk factors used as a basis for project development; strong support groups being fostered among participants by project staff through consistent, in-person and telephone contact; input being solicited from participants incorporated into ongoing program assessment and modification; home visits by a public health educator planned to build family support and alleviate spousal concerns; community youth hired to provide baby sitting and homework assistance services for participant's children during class; interested participants trained to be trainers (nutrition, physical fitness, aerobics, etc.); program marketing by participants through project produced video; and rewards and incentives used to encourage participation and acknowledge achievements (tickets to major events, exercise equipment, food preparation appliances, fitness wear, certificates, etc.)

The success of this community-based health promotion project was recognized in many ways including: The National Award for Excellence 1988—presented by the Secretary of Health and Human Services; project concept solicited for presentation at various domestic conferences (including those of The American Public Health Association, The North Carolina Public Health Association) and other international public health conferences held in Australia, England, and several Scandinavian countries; and consultation provided by project staff to various State Departments of Health and interested community organizations throughout Georgia.

Other measures of success include the participation of nearly 500 community residents in the project, excellent evaluation and statistically significant documented results compiled by Emory University indicating a decrease in systolic and diastolic blood pressure readings of participants, loss of weight and inches, modification of eating habits, improved knowledge of nutrition, increased physical activity and improved self esteem.

In addition the project produced a cookbook with recipes contributed by project participants. All recipes utilized the health principals taught in the nutrition component.

For the purpose of facilitating replication of the project a step by step How to Manual was produced. A companion Video was created to complete the package.

Although this demonstration project was successful based upon community involvement, statistically relevant results and supportive documentation, it suffered from lack of financial support. The original funding by the Centers for Disease Control was extended for three years because of programmatic success. The project was able to secure a fourth year of funding at a severely reduced level from the Kaiser foundation. The available funding did not allow time for the evolution of the community based advisory group into a viable community based non-profit organization with the infrastructure (a strong, working board of directors, long and short term financial strategy, linkage with existing businesses, government entities and elected officials, etc.) necessary to support a project such as CHAPP.

Health issues and the need for health programming are increasing rather than decreasing. It will take initiatives from the highest level, to support successful ef-

forts based upon a community public health promotion model, to be nurtured and allowed to develop to their fullest potential. This type model requires more time, energy and commitment/investment than a clinical model but is well worth the effort as a cost effective and efficient preventive and maintenance intervention rather than a costly crisis intervention strategy.

PROGRAM MODIFICATION

Senator FOWLER. Thank you, Mr. White.

What aspects of the program made it work for these women in your opinion, and were any lessons learned? If we can figure out a way to coordinate the program and get it going again, what would you do differently?

Mr. WHITE. First, the strategy worked and the women became involved because they were allowed to participate in program modification.

For an example, in order to have them attend regularly they required babysitting services, as well as homework assistance for the older children who they cared for, so they were able to bring them to the project site, and their children were taken care of by local high school youth who volunteered and were trained to do that particular function.

Senator FOWLER. The homework, the tutoring?

Mr. WHITE. Yes; also, transportation was provided, if necessary.

Additionally, all of the activities were held in community-based institutions, if you will, that were felt to be safe and secure for the ladies coming out at night.

Also, the fact that the community was allowed, permitted, and demanded to buy into the project, it was not a situation where a project was forced on the community. The idea was brought to the Kirkwood area, and a group of community residents, community leaders, health professionals, and social service workers who worked and lived in the area sat down around a table and discussed the project with CDC and Emory, and based upon that, it was determined that a community needs assessment was necessary, so the project hired community residents to perform 1,800 interviews of the residents of the area to determine what they felt were problems in the area.

In addition to that, another 1,200 were administered questionnaires to determine their particular lifestyles in relationship to cardiovascular high risk factors.

The ladies enjoyed the fellowship—ladyship?—that was developed. [Laughter.]

Mr. WHITE. Sorry.

Senator FOWLER. You are doing fine.

Mr. WHITE. OK. [Laughter.]

And their interest was piqued by the combination of activities. It was not just a single-phase exercise program, there was a music aerobics program, a water aerobics program, and a plain walking program, in addition to various seminars on nutrition, on cooking, on stress, on lower back pain, any number of issues that the participants wanted to find out more information about.

Senator FOWLER. Now, next time how can the Government working hopefully in concert with the universities and the private sector—I keep trying to get the private sector in here because it seems to me like this is the kind of program where they can see the specific results of it—in your opinion, Mr. White, how can we do the job better next time?

Mr. WHITE. The job can be done better by providing resources from the Government sector or the private sector to allow the communities to take complete ownership of the project.

Now, this will require in some instances a little longer time because most community infrastructures do not have the sophistication to develop strong boards of directors which allow long- and short-term funding strategies to be planned, so it means that kind of investment.

Also, the project would be better served, I think, by allowing it to be promoted to the business community in an unstructured setting if you will by doing the videos, by bringing in participants, by sharing the statistical results that were significant as documented by CDC with the business sector, and to encourage them that through their input and their assistance a healthy community means better employees, and better employees mean stronger communities, more vital communities which enhance their opportunities to make money, conduct business, as well as building stronger communities in the Nation.

Senator FOWLER. Thank you, Mr. White, very, very much.

STATEMENT OF GLORIA CLAYTON

Next, we will switch a little bit and talk about the problems of women in the later years. We have Dr. Gloria Clayton from Augusta, a professor of nursing at the Medical College of Georgia.

Dr. Clayton, welcome.

Dr. CLAYTON. Thank you, Senator Fowler.

I appreciate the opportunity to be present today.

I recognize the difficult decisions you must make as a member of the Appropriations Committee during a time of increasing need and decreasing funds. We Georgians are very proud of your contributions, and we are pleased to have this hearing conducted at the CDC today.

I want to talk to you about issues of older women in the State of Georgia. I am from south Georgia, Senator, and I am not going to speak anywhere near as rapidly as Dr. Floyd. [Laughter.]

But I do not want that to diminish the concerns of older adults, for indeed they are great, and as I have listened to the other members of the panels today, I am more concerned about aging issues as I hear about issues of children and younger women, for indeed the issues of aging are going to become more complex.

Currently, the fastest growing segment of the population in the United States is individuals 85 and over. Unfortunately, this age group is very underinvestigated. We have addressed elderly individuals as though they were one age group, and it simply is not feasible to assume that individuals ranging in age from 60 to 100 belong to the same age group. In no other group on the life span do we make this error.

This fallacy would be assuming that someone at the age of 50 has similar concerns and issues as an individual of 30, or similar concerns and issues as an individual of 70. For us middle-agers, the difference is startling, and yet most of the research done on elderly individuals today does not distinguish what we are now calling the young old, people under the age of 85, and the oldest old, people over 85. In terms of physical health, environmental support, demographic statistics, and socioeconomic status the two groups are very, very different.

Of this exponentially increasing population of elderly adults, the majority are women. Their demographic profiles differ drastically from that of older men. Specifically, women are more likely to live alone, to have a lower economic level, have less resources available to them.

Women are more likely to continue to be care providers, many times even to a very old age. It is very typical in Georgia and in the rest of our country to have a woman in her seventies providing care for an even older family member. Additionally, particularly in minority families, this care provider may also be taking care of grandchildren.

We know that health promotion and disease prevention programs need to be targeted toward specific behaviors. Illness is behaviorally related, and behaviors are gender-specific.

The problem of addressing health care programs for older women is very compromised by our lack of knowledge of developmental issues. Most research done on development in this country has been conducted on male subjects. We know very little about developmental issues for women, and absolutely nothing about developmental issues for older women.

A preliminary step in developing health care programs targeting older females is the generation of knowledge about developmental issues and gender-specific health behaviors. An example may serve to clarify.

Levinson and his colleagues with about 8 or 10 years of support from the National Institute of Mental Health investigated the critical issues of concern to men 35 to 45 years of age. Knowledge generated from this research helps us to specify interventions like relaxation therapy, cardiac rehab programs, stress management programs. These health promotion and disease prevention programs are very effective, and they are much cheaper than the cost of a heart attack or putting someone on a heart pump and replacing some clogged arteries.

Senator, I would like to tell you about a Georgia family that I have had the opportunity to interact with as an NIMH grantee over the last 3 or 4 years, and use three of the women members to illustrate what we know and the major gaps concerning health promotion in women.

In a rural Georgia community, I visited with a woman who is 100. She lives with her daughter who is 78. Next door to these two women live the centenarian's grandchild who is a high school teacher. Her husband is also a teacher and a coach. Typical of most American families, both parents work. They have two high school age children.

The grandmother, the 100-year-old person, is active. She goes to church and the beauty parlor every week, she dresses herself, she bathes herself, and maintains many social contacts. She is now beginning to have periods of small pin strokes which are followed by confusion for several hours.

The family is beginning to talk about the possibility of putting her in a nursing home due to this confusion and several resulting medication errors. This would be a travesty causing an extremely emotional situation from the family. From what we know about institutionalization our expectation is that the woman will decline rapidly.

To propose the type of intervention which would allow her to remain in her home with her daughter is hypothetical at this point. We do know that nursing homes are the most expensive intervention. Perhaps a visiting nurse service, as we have discussed in other parts of the panel, or a day care respite program would be an appropriate intervention.

Confusion is a serious problem not only for this Georgia grandmother, but for many elderly. Confusion increases the chance of institutionalization, prolongs hospitalization, and increases the frequency of physician visits. These interventions are expensive and they do not cure confusion.

One grantee from the National Center for Nursing Research is developing an instrument to assess problems with information processing of the elderly. This instrument would allow nurses in the hospital and long-term care facilities and visiting home nurses to quickly assess the specifics of an individual's problems with processing information so that the intervention could be targeted specifically to that individual and could be based on the context in which they reside. We simply do not have that information yet.

Other problems typical in women over 85 are immobility, incontinence, strength decreases, imbalance, and loss of independence. In blacks, hypertension continues to be a major problem.

Members of this grandmother's age group are at greater risk for Alzheimer's disease and other dementias. Dementia risk increases with age to an expected 25 percent in the oldest old.

The 78-year-old care giver in this family has osteoporosis. If she lives to be 100, she will not be as independent as her mother. The prevalence of osteoporosis is increasing in middle age and older age females. We need models of providing early education to prevent this disease. As usual in health care, prevention will be much less costly than treatment.

The issue of old women caring for even older family members is an increasing phenomenon placing two generations at risk. We know very little about the problems experienced by such diads and cost-effective intervention to assist them.

We do know that among persons over 65, 85 percent experience one chronic illness, and 50 percent report activity limitations due to health problems. In this age group, women constitute more than 60 percent of the population, and the sex differential increases as age increases. Older women are more likely to have physical disabilities such as joint disfunction.

Depression is a very serious problem occurring in nearly 27 percent of community dwelling elderly, and largely is untreated.

Women in this age group also have serious nutritional inadequacies.

Heart disease is the No. 1 killer followed closely by cancer for No. 2. Nearly 5,000 women over the age of 60 die each year from uterine cancer, a disease with a cure rate of 85 percent when detected early.

Clearly, we need to develop and test gender-specific educational protocols which cause women to change the behaviors leading to expensive medical conditions.

The 51-year-old daughter or granddaughter in this Georgia family is pivotal to the independence of her mother and her grandmother. She is the buffer to step in when flu or any other episodic illness occurs. She characterizes what we are calling the woman in the middle in that her roles of homemaker and paid worker are stressed by meeting the needs of children and older family members. This woman is currently being treated for breast cancer. Fortunately, she is expected to survive, but her treatment is difficult, expensive, and necessitates a 2½-hour drive to a medical center.

Women in the middle are considered when discussing health of the elderly not only due to their position as care providers, but also because their own health promotion behaviors are a determining factor for their condition at old age.

What education protocol would result in a middle aged woman choosing annual mammography? Education and health promotion at age 51 might prevent this daughter from developing the osteoporosis which her mother is now suffering.

Some important preliminary findings are coming out of our current project funded by NIMH, the Georgia Centenarian Study, which is investigating three age groups of older Georgians: Persons 100 years and older, 80 to 89, and 60 to 69. We know that physical decline increases with age, but we are seeing that that can be buffered by good mental health and high-life satisfaction.

We have many compromised very old adults maintaining independence through families' ability to provide specific support at critical times.

While research supports inadequate nutrition among the young old, we find robust Georgia centenarians with very high caloric intakes meeting RDA suggestions.

Preliminary findings indicate that a female older adult's personality seems to serve as an important resource. Women who are outgoing and tough-minded show much higher levels of current morale and life satisfaction. It seems important that families and communities need to encourage and reward women who reach out and who often as pioneers in aging face their health and family concerns in a self-reliant manner.

Church activity serves as a social and coping need for elders. While some cognitive functions decline with age, our oldest old subjects score quite well on the ability to solve daily problems.

There is only a 1 in 10,000 chance for an individual in Georgia today living to be 100. There is something very special to be learned from those persons who have reached that age and are still able to maintain independent living in the community.

As in all research, we have found many answers, but we are also developing more questions. Interdisciplinary faculty across two universities at the Gerontology Center at the University of Georgia enhance our resources for discovering answers.

PREPARED STATEMENT

By the year 2000, there will likely be 10 women for every 5 men over the age of 75. By 2035, 33.4 million American women will be 65 or over. Increased survivorship has created both problems and potential for older women. The challenge for the future is helping women respond to aging in a manner that enhances their potential and diminishes their problems. An understanding of the major milestones in the lives of women is needed to assist them in developing the skills to lead multidimensional lives as persons with well rounded identity, and to adjust to major life events successfully.

Thank you very much, Senator.

[The statement follows:]

STATEMENT OF GLORIA M. CLAYTON

Thank you, Senator Fowler, for the opportunity to be present at the hearing today. I appreciate the difficult decisions you must make as a member of the Appropriations Committee during a time of increasing need and decreasing funds. We Georgians are proud of your important contribution and pleased to have this hearing conducted at the CDC in our state.

I would like to discuss with you today the needs of older women in the state of Georgia and the United States concerning health promotion and illness prevention. My information is based on a review of the research literature, my current experience as an NIMH grantee which has allowed me to spend the last three and a half years traveling the state of Georgia interviewing older adults, and my experience as a registered nurse for over 25 years.

Currently, the fastest growing segment of the population in the United States is individuals 85 and over.[1] Unfortunately, this age group is very under-investigated. We have addressed elderly individuals as though they were one age group and it simply is not feasible to assume that individuals ranging in age from 60 or 65 to 100 plus belong to the same age group. In no other age group do we make this error. This fallacy, Senator, would be assuming that someone at age of 50 has similar concerns and issues as a man 30 and/or similar to an individual 70. For us middle-agers the difference is startling, and yet most of the research done on elderly persons to date does not distinguish individuals into what we now call the young-old, those persons under the age of 85, and the oldest-old, persons 85 and older. In terms of physical health, environmental support, demographic statistics, and socioeconomic status, the young-old and oldest-old are very, very different.[2]

Of this exponentially increasing population of elderly adults, the majority are women. Their demographic profile differs drastically from that of older men. Specifically, women are more likely to live alone due to widowhood or divorce, have a lower income level than that of males, and have less resources available to them. Women are more likely to be care providers for other family members and/or grandchildren of working children. It is very typical in Georgia and the rest of our country to have a women in her seventies providing care for an even older family member. Additionally, particularly in minority families, this care provider may also be taking care of grandchildren. We know that health promotion and disease prevention programs need to be targeted toward specific behaviors. Illness is behaviorally related and behaviors are gender specific. The problem of addressing health care programs for older women is very compromised by our lack of knowledge of developmental issues. Most research on development in this country has been conducted on male subjects.[3] We know very little about developmental issues for women and absolutely nothing about developmental issues for older women. A preliminary step in developing health care programs targeting older females is the generation of knowledge about developmental issues and gender specific health behaviors. An example may serve to clarify. Levinson and his colleagues[4] with support from NIMH investigated critical issues in males 35 to 45 years of age. Knowledge generated from their work allows us to specify such interventions as stress management, relaxation therapy and cardiac rehabilitation programs. These health promotion and disease prevention programs are effective and much cheaper than the cost of a heart attack or putting someone on a heart pump and replacing clogged arteries.

Senator, I would like to tell you about a Georgia family and use three of the female members to illustrate what we know and the major gaps concerning health promotion in women. In a rural community in South Georgia, I visited with a women who is 100. She lives with her daughter who is 78. The only other sibling is a physician in this rural county who is 70 years old and still engaged in a very busy rural family practice. Next door to the two older women lives the centenarian's grandchild who is a high school teacher. Her husband is a high school teacher and coach. Typical of most American families both parents work. They have two high school age children. The boy is involved in every sport the school offers. The daughter is a cheerleader and a member of the debate team. The entire family is very loving and supportive of both older women and yet they are all very busy.

For clarity, and to protect the anonymity of the family I will refer to the 100 year old woman as the grandmother, the 78 year old care giver as the mother and the 51 year old school teacher as the daughter. The grandmother is active, goes to church and the beauty parlor weekly, dresses and bathes herself, and maintains many social contacts. She is now beginning to have periods of small pin strokes followed by confusion for several hours. The family is beginning to talk about the possibility of putting her in a nursing home due to this confusion and several resulting medication errors. This would be a travesty causing an extremely emotional and sad situation for the family. From what we know about institutionalization, our expectation is that the woman will decline rapidly. To propose the type of intervention which would allow the woman to stay in the home with her daughter is hypothetical at this point. We do know that a nursing home is a very expensive intervention, perhaps a visiting nurse or a day care respite program once a week.

Other problems typical in women over 85 are immobility, incontinence, strength decreases, imbalance and loss of independence. In blacks, hypertension continues to be a major problem. Some important research is ongoing addressing some of those issues, specifically a study of frailty, injuries and techniques for intervention sponsored by NIA and NCNR. Another NCNR grantee is developing an instrument to assess problems with information processing in the elderly. Confusion is a serious problem not only for the Georgia grandmother, but many elderly. Confusion increases the chance of institutionalization, prolongs hospitalization and increases the frequency of physician visits. These interventions are expensive and do not resolve confusion.

Members of this grandmother's age group, those over 85 years, are at greater risk for Alzheimer's disease and other dementias. Dementia risk increases with age to an expected occurrence of 25 percent in the oldest-old.[5]

The 78 year old caregiver in this family has osteoporosis. If she lives to 100 she will not be as independent as her mother. The prevalence of osteoporosis is increasing in middle and older-age females. We need models of providing early education to prevent this disease. As usual in health care, prevention will be much less costly than treatment.

The issue of old women caring for even older family members, as seen in this Georgia family, is an increasing phenomenon placing two generations at risk. We know very little about the problems experienced by such dyads and cost-effective intervention to assist them.

We do know that among persons over 65 and older 85 percent experience one chronic illness and 50 percent report activity limitations due to health problems.[6] In this age group, women constitute more than 60 percent of the population and the sex differential increases as age increases. Older woman are more likely to have physical disabilities such as joint dysfunction.[7] Depression is a serious problem occurring in nearly 27 percent of community dwelling elderly and is largely untreated.[8] Women in this age group have serious nutritional inadequacies. In one study of middle class, older women, subjects ingested less than two-thirds of the RDA of several important nutrients.[9] Heart disease is the number one killer in this age group followed closely by cancer for number two. Nearly 5,000 women over the age of 60 die each year from uterine cervical cancer, a disease with a cure rate of 85 percent when detected early.[10]

Clearly, we need to develop and test gender-specific education protocols which cause women to change the behaviors leading to expensive medical conditions. These protocols must also be sensitive to rural/urban idiosyncrasies as well as differences based on ethnicity and income levels.

The 51 year old daughter in the Georgia family is pivotal to the independence of her mother and grandmother. She is the buffer to step in when flu or other episodic illnesses occur. She characterizes the "woman in the middle"[11] in that roles of homemaker and paid worker are stressed by meeting the needs of children and older family members. This woman is currently being treated for breast cancer. Fortunately, she is expected to survive but her treatment is difficult, expensive and necessitates a 2½ hour drive to the oncologist.

"Women in the middle" are considered when discussing health of the elderly, not only due to their position as care providers, but also because their own health promotion behaviors are a determining factor for their condition in old age. What education program would result in middle-aged women choosing annual mammography and decreasing the high cancer rate? Education and health promotion at age 50 could prevent this daughter developing the osteoporosis from which her mother now suffers. Women in the middle must make decisions about hormone therapy post-menopause and the evidence is inconclusive about what advice to give them. Changes in gut function, menopausal symptoms, sleep disturbance and stress resulting from multiple roles all require intensive research to improve the health and well-being of this age group.

Some important preliminary findings are coming out of our current project, the Georgia Centenarian Study (Ref #1 RO1 MH 43435), which is investigating three age groups of older Georgians: 100 years and over, 80–89, and 60–69. We know that physical decline increases with age but is buffered by good mental health and high life satisfaction. We have many compromised very old adults still maintaining independence through families' ability to provide specific support at critical time periods.[12] While research suggests inadequate nutrition among the young old, we find robust centenarians with very high caloric intake in frequent feedings meeting RDA suggestions.[13]

Preliminary findings indicate that for female older adults personality seems to serve as an important resource. Women who were outgoing and tough-minded showed much higher levels of current morale, while women who have high levels of anxiety typically had low levels of morale. It seems important that families and communities need to encourage and reward women who reach out and who—often as pioneers in aging—face their health and family concerns in a self-reliant manner.[14] Church activity serves a social and coping need for elders.[15] Health education through churches may be an effective intervention. One NCNR grantee is testing such a protocol with a younger population.

While some cognitive function declines with age, our oldest subjects score quite well in the ability to solve daily problems.[16] Perhaps this allows them to maintain independence but how do we teach individuals to retain problem-solving ability? As in all research as we find some answers we also are developing many questions. Inter-disciplinary faculty across two universities at the Gerontology Center at the University of Georgia enhance our resources for discovering answers (See Appendix). By the year 2000, there will likely be ten women for every five men over the age of 75. By 2035, 33.4 million American women will be 65 or over.

Increased survivorship has created both problems and potentials for older women. The challenge for the future is helping women respond to aging in a manner that enhances their potentials and diminishes their problems. An understanding of the major milestones in the lives of women is needed to assist them in developing the skills to lead multidimensional lives as persons with well-rounded identities and adjust to major life events successfully.[17]

Senator Fowler, I appreciate the opportunity to present testimony here today. I hope this information will be helpful to you and your committee as you make decisions important for all Americans. I would be happy to respond to any questions.

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PROBLEMS OF OLDER AMERICAN WOMEN

Senator FOWLER. Thank you very much, Dr. Clayton.

Let me ask you, you have obviously done some groundbreaking research in the problems of older American women. Go back again on this gender-specificity, we have got—oh, I do not know, I do not have the latest figures, but I know from the debate on catastrophic health insurance in the Congress that there are certainly over 2 million Americans living in nursing homes at a cost of over $50 billion private and public cost. You have been reading about how we are all in Washington trying to work on a program of comprehensive health coverage, to do something about these escalating costs. More and more people if they identify the primary need, it is for money, insurance of some kind for nursing home care.

Again on the issue of gender specificity, what is it specifically that leads women as opposed to men in the nursing homes? Can you identify that, is it other than aloneness?

Dr. CLAYTON. Aloneness is certainly part of it.

Senator FOWLER. A large part of it, I assume.

Dr. CLAYTON. A large part of it, particularly for women who do not have other family members living close by in the community, because there are some decreases in activity levels, which if someone can provide one service a day, if someone can provide help perhaps in bathing the woman then she is able to remain in the home, she can do everything else but needs some assistance.

Senator FOWLER. Right.

Dr. CLAYTON. But in answer to your question about institutionalization, currently only about 5 percent of the population that I study are institutionalized, so most of our elderly are living in the community.

It is also a myth, perhaps too well known or considered, that families tend to dump their older members in nursing homes. It is not just the cost of institutionalization that is of concern to me, but the cost to the families. It is a very traumatic situation in a family to have to institutionalize an older family member, and not a decision that they make easily.

The three big causes of institutionalization are immobility, incontinence, and confusion. None of those are cured by institutionalization.

Senator **Fowler**. Are those three factors more prevalent in women than men?

Dr. **Clayton**. More women are institutionalized because of those three factors than are men.

Senator **Fowler**. Why?

Dr. **Clayton**. Because men tend to have a woman in the home who can provide care for them.

Senator **Fowler**. There is the answer. [Laughter.]

I am certainly glad I kept pushing. [Laughter.]

Dr. **Clayton**. Older men tend to be married to younger women, and it is a very smart thing for them to do. [Laughter.]

Senator **Fowler**. I can assure you I am smart enough not to comment on that. [Laughter.]

Dr. **Clayton**. It may be that we need an educational protocol that teaches women how to be married to younger men so that they have a care giver. [Applause.]

Senator **Fowler**. Since some defense is necessary, I can assure you will get a new set of public problems. [Laughter.]

Do they fall more often? Do older women fall more often, break their hips more often than men?

Dr. **Clayton**. No; more women——

Senator **Fowler**. Any other gender-specific accidents that lead to what you call immobility?

Dr. **Clayton**. Older women tend to drive longer than older men, so older women are more involved in automobile accidents and suffer immobility or serious injury from driving. I think women tend to do that because of their role of care provider, that we continue into very advanced age to hang onto that role, and so they drive so that they are providing care, or are able to provide care to other family members.

Senator **Fowler**. Well, in conclusion, Dr. Clayton, how lacking are we in the public and private resources, the means to prevent many of these problems that you have identified?

Dr. **Clayton**. I think that probably the greatest factor to providing some change in the problems that we are experiencing is a problem that might be—I thought that was well defined as hardening of the category in an earlier presentation. We have too little interdisciplinary work in terms of science, and also in terms of health care delivery, and families and individuals live in a very contextual situation, so what works for one Georgia family might not work for another Georgia family, so by the process of having a very integrated approach and having many people from different disciplines work on a team to assess a situation and develop protocols for intervention we are more likely to be successful, but we are not doing that. That is not the way the funding system works.

I get funded as a scientist from the National Institution of Aging or from the National Institute of Mental Health, and only recently has there been a push for my work to be interdisciplinary work.

I think we need to reinforce the policy of NIH now in pushing interdisciplinary work, but we also need to do that locally in forums such as this.

I do not have acquaintanceship with anybody at the CDC who does similar work to what I do, and I am sure there are scientists here with whom I could collaborate, and that integration of the academic environment and the prevention environment here would make for much sounder science, but we have to get around the red tape or the bureaucracy of the funding.

Senator **Fowler**. Well, that is a fine introduction for you, is it not, Ms. Bales? [Laughter.]

Dr. Clayton, thank you. That was educational as well as revealing.

STATEMENT OF VIRGINIA BALES

Last, but certainly not least, Ms. Virginia Bales who is the Deputy Director of CDC's Center for Chronic Disease Prevention and Health Promotion.

Glad to see you.

Ms. **Bales**. Thank you, Senator.

The speakers here today have vividly and eloquently described some of the health problems that American women are facing, and Georgia women. They have described prevention programs that work, and that are working in our community.

I have a written statement that describes in more detail many of CDC's efforts. CDC, the Nation's prevention agency, is doing much to help States and communities nationwide prevent many of these conditions, and reduce the attendant burden of death, disability, and the unmanageable health care costs that we are experiencing.

I would like to highlight in my oral statement three areas: First, breast and cervical cancer.

You have heard several times today, and I will tell you again that 175,000 women will have breast or cervical cancer diagnosed in the United States this year. Nearly 50,000 women will die of breast or cervical cancer, roughly the population of Rome, GA, gone this year, next year, last year.

You have heard Dr. Connell and Mrs. McIntyre speak urgently of the need for early detection in women's cancers, and of the efficacy of simple screening procedures for early detection that is essential to prevent needless death. Breast and cervical cancer are not yet preventable, yet with early detection, virtually all cervical cancer deaths and nearly 40 percent of breast cancer deaths can be prevented.

CDC is laying the groundwork for a nationwide comprehensive cancer control program that will include screening services, particularly for low-income women, professional training for healthcare providers to improve their diagnostic skills, but also to ensure that screening becomes a standard part of medical practice, quality assurance programs, and a very vigorous public information program to activate the American woman. This program will be expanded to seven to nine States this year, and is authorized by the Breast and Cervical Cancer Mortality Prevention Act of 1990.

Senator, when you and your colleagues in the Congress passed this landmark legislation last year and funded it, you gave the gift of life to thousands of American women. Thank you.

Promoting healthy lifestyles that Mr. White described. The choices that we as American women make in our diet, in physical activity, in tobacco use, in sexuality, profoundly affect the length and quality of our lives due to heart disease, to lung cancer, sexually transmitted diseases and AIDS, unintended pregnancy, falls, hip fractures, arthritis—the list goes on—all problems that are especially important to women.

Mr. White gave us a glimpse at one successful community-based program which focused on physical activity and proper diet to control obesity, not a trivial issue. Over one-half of poor women are overweight, a condition associated with elevated cholesterol, high blood pressure, heart disease, some cancers, and osteoarthritis.

Programs like the Kirkwood project that empower communities to make decisions and take control of their health outcome, that target physical activity, diet, smoking, injury prevention, and other behavioral risk factors are sponsored by CDC in communities all around the country.

I do want to stop and emphasize tobacco. Tobacco use is the single most preventable cause of death and disability in this country. Every day over 3,000 Americans, mostly teenagers, begin to smoke. More teenage girls smoke than teen boys, and fewer women quit than men.

We are paying the price as women. Lung cancer has now passed breast cancer as the No. 1 cancer death among American women.

Finally, Dr. Clayton has shared with us the hardships of some diseases and conditions affecting the elderly, and the related burdens on their family members. CDC has research and prevention programs for Alzheimer's disease, arthritis, immobility, incontinence, influenza, osteoporosis, and injuries, to name a few.

Just take osteoporosis for example, the thinning of bones which is the leading cause of bone fractures in women over 65, and causes 1.3 million fractures each year. Most hip fractures occur in older women. The known modifiable risk factors for fracture are calcium intake, weight-bearing activity, tobacco, alcohol, and caffeine use. CDC has continued to develop and implement research and prevention efforts to reduce the toll of hip fractures on older women.

I would hope that we as a Nation would apply prevention early as in the earlier panel and many ideas that were brought out in that panel, and continually throughout our adult and elderly lives to improve not just the length of our lives, but the quality of our lives, but if that argument is not adequately persuasive then consider the price tag.

We spend more than any other nation on health care, and yet our health status is dismal by comparison.

PREPARED STATEMENT

The long-run solutions to many of these problems lie in the kind of common-sense prevention efforts which have undergirded the testimony of all of the panelists today. Moderate exercise, a healthy low fat diet including adequate calcium, no tobacco, early diagnosis and treatment of cancers and other conditions, influenza vaccination, a safe environment are all tools we have now at hand, they are prevention tools scientifically tested, cost effective, and proven to work.

[The statement follows:]

STATEMENT OF VIRGINIA S. BALES

Good morning, Mr. Chairman. I am pleased to be here to highlight for you some of CDC's programs in women's health.

The panel, "Women Leading Healthy Lives," in keeping with the theme of this hearing, highlights the positive side of the health equation. It has shown that many diseases and conditions, which threaten both life and the quality of life for thousands of women, may be successfully managed by early detection, or prevented by the lifestyle choices women make.

Because of time constraints, the panel could not cover all of the concerns for women's health, but it is a substantial start. Other diseases and conditions, all affecting women, are also being given close attention by CDC—heart disease, lung cancer, HIV infection, sexually transmitted diseases, to name a few. I will also summarize our major activities in those areas for the record.

Mr. Chairman, I would now like to share with the Committee a brief overview of what CDC, the Nation's prevention agency, is doing to protect and promote the health of women.

BREAST AND CERVICAL CANCER

The passage by Congress of the Breast and Cervical Cancer Mortality Prevention Act of 1990 opened a new window of opportunity for the expansion of CDC's existing cancer prevention program.

This state-based comprehensive program, now well under way, combines the efforts of other State programs, other Federal agencies, national organizations, and voluntary agencies. This year we will fund 7–9 States which are developing the capacity to provide breast and cervical screening services, and appropriate referrals and follow-up to women, particularly low-income and native American women.

Key elements of the program are: public information and education efforts to increase the utilization of screening services; monitoring the quality of the screening process; professional education for health care providers to improve their skills in health education, screening, diagnosis, and treatment; and appropriate surveillance and epidemiological studies—the assessment tools essential to monitor the results of prevention programs.

Cervical cancer screening among low-income elderly women is shown to yield a net savings of at least $1,600 per person. Early diagnosis of breast cancer saves about $59,000 in treatment per tumor. More importantly, without these efforts, more than 1.5 million American women will die needlessly this decade from breast and cervical cancer. With effective screening, soon to be available through these programs, deaths from cervical cancer can be virtually eliminated and deaths from breast cancer can be reduced more than 30 percent in the areas having programs.

SEXUALLY TRANSMITTED DISEASES, PELVIC INFLAMMATORY DISEASE, AND INFERTILITY

The adverse consequences of sexually transmitted diseases (STD) disproportionately affect women, particularly racial/ethnic minority women and their infants. Women are at risk for numerous and costly side effects of STD, including infertility, ectopic pregnancy, miscarriages, and possibly cervical cancer associated with human papillomavirus. In fact, we know that the only preventable causes of infertility are those which result from STD and pelvic inflammatory disease. Also, women of childbearing age (15–44 years old) represent 85 percent of all reported cases of AIDS among women. Pediatric AIDS cases now represent 1.7 percent of all AIDS cases.

To address these issues, CDC supports targeted screening programs to identify gonococcal infection in women and to notify sex partners of infected women. CDC will also be providing grants to States to support screening for *Chlamydia trachomatis* infection, a major cause of pelvic inflammatory disease, in selected STD, prenatal, and family planning clinics. Ongoing surveillance efforts for syphilis should allow us to determine the populations at greatest risk and to develop better techniques to reach women who do not receive adequate prenatal care.

Georgia currently has the highest rates of primary and secondary syphilis in the country. Since 1985, when the increase in syphilis cases began in this State, the rates have increased faster for women than for men. In 1990, 106 of 159 Georgia counties had syphilis rates exceeding the 1990 national objective of seven cases per 100,000 population. Thirteen rural counties had rates exceeding 100 cases per 100,000 population. Recent national studies have also shown the association of cocaine use with high rates of syphilis among women having children and resultant increases in the incidence of congenital syphilis.

AIDS prevention projects in seven cities focus on racial/ethnic minority women in drug treatment programs to identify and remove impediments to use of contraception and to encourage behavior change to reduce the risk of acquisition and transmission of HIV

PROMOTING HEALTHY LIFESTYLES

The panel has described the Kirkwood Project, one of CDC's community-based health promotion programs co-sponsored by Emory University School of Medicine and developed at the Dekalb-Grady (Georgia) Neighborhood Health Center.

This program is comparable to CDC's Planned Approach to Community Health (PATCH) Program, which has been adopted in 52 communities in 20 States. Initiated in 1984, the PATCH program strengthens the collective capacities of state and local agencies to plan and deliver health promotion programs targeted at community-determined priorities. Program components include community organization, data collection, prioritization, determining objectives, intervention planning, and evaluation. The 52 communities have identified health priorities ranging from cardiovascular disease to injuries and unintended pregnancy and have intervened on specific risk factors such as cigarette smoking, safety belt use, and inactivity.

The Kirkwood Project addresses specifically the disturbing fact that about one quarter of the U.S. population—some 60.5 million Americans—are overweight, a condition associated with a variety of serious and debilitating disorders, including elevated cholesterol, high blood pressure, coronary heart disease, non-insulin dependent diabetes, certain cancers, and osteoarthritis of the knee, among others. Cardiovascular disease alone accounts for $136 billion annually in health costs and low productivity for all Americans. The poor and minorities bear a disproportionate share of the disease burden resulting from obesity. Over 50 percent of poor women are overweight and 40 percent of black and Hispanic women are severely overweight.

The 1996 Olympics in Atlanta offer a unique opportunity for us to highlight the important health benefits of physical activity. CDC has provided national leadership in defining the role of physical activity and its impact on health.

Although Americans spend almost $30 billion on weight loss programs and diet books, the most effective method of sustained weight and fat reduction is a dual regimen of exercise combined with proper nutrition. The Kirkwood Project in Atlanta and PATCH provide an opportunity for communities to address such preventable women's health problems as obesity and physical inactivity.

Tobacco use is the single most preventable cause of death and disability in our nation. This one behavior results in over 1,000 American deaths each and every day, and costs the nation over $65 billion each year. Despite these staggering human and economic costs, nearly one-third of all adults in the United States continue to smoke, and it is estimated that each and every day over 3,000 Americans, most of them teenagers, take up smoking. Since 1977, smoking prevalence has been higher among female than male high school seniors. Furthermore, the decline in smoking prevalence among women has been slow—slower, in fact, than among men. This is particularly alarming because lung cancer has surpassed breast cancer as the number one cause of cancer death among women.

CDC's Office on Smoking and Health is the focal point within the Federal government for smoking and health. That Office works in close collaboration with relevant government, voluntary, and professional organizations to develop and implement a multi-faceted national strategy to reduce and prevent tobacco use, especially among minorities, women, and children and adolescents. CDC's award-winning public service announcements directed at teens, pregnant women, and mothers are the cornerstone of our public information campaigns.

CDC's 1992 program plans include increasing and strengthening technical assistance to the States, with special emphasis on effectively mounting and sustaining broad-based tobacco education programs; continuing and expanding vigorous public information campaigns to fully advise the American public of the dangers of tobacco use; working in close collaboration with the health and education organizations to develop guidelines for school programs designed to educate youth on the hazards of tobacco use and to prevent tobacco use in schools; and better targeting interventions to those at greatest risk, such as minorities, women, and children.

Smoking cessation programs aimed at specific population groups are cost-effective, and a combination of interventions is the most effective method of reducing tobacco use. A rigorous evaluation of health curricula in schools has shown that education programs do deter youths from starting to smoke.

QUALITY OF LIFE IN LATER YEARS

Arthritis affects an estimated 37 million people with a cost to the nation of $16.3 billion annually. Arthritis and related conditions increasingly affect the elderly, the fastest growing segment of our society. These diseases contribute to 20 percent of all instances of homebound individuals and to more than 15 percent of all applications for Social Security disability. CDC focuses attention on two of the most prevalent arthritic diseases—osteoporosis and osteoarthritis.

Osteoporosis is the leading cause of bone fractures in women over 65. It affects 25 million Americans and causes 1.3 million fractures each year. In addition to the crippling disability of osteoporosis, often requiring institutionalization, its annual total cost in 1986 for treatment and institutional services was estimated to be $7 to $10 billion.

Osteoarthritis, the most common form of arthritis, affects 16 million Americans and often results in severe disability requiring joint replacement surgery. The estimated national expenditure for these operations exceeds $3 billion annually.

CDC's efforts to address these disabling diseases are centering on coordinating state arthritis programs, expanding the number of states which have arthritis programs (less than 20 percent of the states now have structured arthritis programs) and developing a uniform effort, which will still be flexible enough to meet the needs of individual states. CDC is presently identifying those states that have effective programs.

Education programs which address the known modifiable risk factors for fractures—calcium intake, weight bearing physical activity, use of tobacco, alcohol, and caffeine—can effect significant reductions in the high price paid in painful disability and health costs for these conditions. Bone mass can even be increased in sedentary women who start exercising, thus reducing the likelihood of fractures.

Alzheimer's, the leading cause of dementia, is characterized by deterioration of memory, orientation, general intellect, specific cognitive capacities, and social functioning. In 1990, there were 3.75 million Americans suffering from this disease for which age is the only generally accepted risk factor (a very small percentage of dementias are recognized to be familial and genetic). With the aging of the population the numbers of affected people are expected to increase to 4.51 million by the year 2000 among the non-institutionalized elderly.

Good data about the prevalence of dementias are nearly non-existent and undercounting has resulted from patient, family, and even physicians' acceptance of "senility" as a normal part of aging. CDC is first turning its attention to acquiring an accurate accounting of the burden of the disease.

Falls are the leading cause of death from injury in people 65 and older, resulting in more than 9,000 deaths annually. Seventy-three percent of all deaths from falls occur to persons 65 or older. Also the rate of nonfatal falls increases exponentially by age for older persons. Hip fracture, one specific injury type, is a major cause of death, disability and high medical costs in older persons. More than 230,000 hip fractures occur annually to men and women over 65, with 77 percent occurring among women. Many of these fall-related injuries occur within several months of discharge from a hospital for nonfall-related disease.

CDC has continued to develop and implement research and program efforts to reduce the toll of falls and hip fractures on older Americans. Notable among these efforts has been the initiation of a landmark research project entitled "Epidemiologic Study of Injuries Among the Elderly—Project SAFE." This study, undertaken jointly with the Dade County, Florida Department of Public Health, is identifying factors which contribute to injuries among the elderly, will develop and test interventions, and develop prevention models for use by health agencies nationwide.

CDC is also looking into a number of other factors which may be relevant to fractures. For example: Estrogen use; medication use such as psychoactive drugs which are used frequently by elderly individuals; body fat; and environmental conditions in the home.

We have already developed a significant environmental hazard scoring mechanism which helps identify ways to ensure greater safety in the home environment.

IMMUNIZATION OF THE ELDERLY

Epidemics of influenza occur almost annually in the United States. While influenza affects all age groups, there is a particularly high incidence among the elderly, and there is a correspondingly higher mortality rate among the elderly. For example, it has been estimated that the influenza epidemic of 1984–85 caused 50,000 excess deaths (i.e., deaths that would not have occurred in the absence of an epidemic), and 200,000 excess hospitalizations, and cost approximately $10 billion. Eighty to ninety percent of these deaths occur in persons 65 or older.

Prevention strategies for influenza virus focus on the use of vaccines in high risk populations which include the elderly. The major impediment to controlling influenza by vaccination has been the ability of the virus to undergo antigenic change at a rapid rate. Because of these rapid changes, immunity induced to previous influenza strains may not be sufficient to protect against the more current strains. Therefore, the vaccine must be updated annually and administered to the target population annually.

CDC participates in the Interagency Working Group on Influenza to outline the steps to be taken in the United States in the event that a new pandemic strain of influenza should arise. It monitors the antigenic and genetic characteristics of newly emerging viruses and uses this information to determine the composition of next year's vaccine.

Despite the fact that influenza vaccine is approximately 75 percent effective in reducing deaths in high-risk elderly persons, in 1985 only 23 percent of persons 65 or older reported receiving the vaccine in the past year. By 1989, this percentage had only risen to 30 percent. Many factors have influenced the utilization of vaccines among the elderly, including the lack of awareness of the availability of safe, effective vaccines, fear of adverse reactions, and apathy among both consumers and health providers.

CDC is implementing a number of important strategies to improve immunization of adults. As in most of our agency's activities, we work with and through State health departments to accomplish these program goals. These include: Strengthening information-sharing and educational activity among lay and professional groups; assessing patterns of vaccine usage and coverage in target populations such as the elderly; development of special programs to improve vaccine delivery to certain target groups, such as residents of nursing homes and older persons living at home; and assisting in the development of curriculum components on adult immunization practices for undergraduate and post-graduate medical students.

CONCLUSION

The list of diseases and conditions I've highlighted represent some of the major health hazards facing adult women—hazards which, without effective preventive efforts, will continue to exact a heavy cost in death, disability, and unmanageable medical expenses. As we've heard today, many of the prevention tools are already at hand and are ours to use for our better health. We have heard throughout the testimony that behavior choices such as smoking, improper dietary habits, and sedentary lifestyle, to name a few—all matters of choice—place not only women, but all Americans at high risk for killing and disabling diseases. We have heard how early screening procedures can, for instance, virtually eliminate deaths from cervical cancer, and greatly reduce those from breast cancer. These are prevention tools within our grasp now. It is CDC's mission as the nation's prevention agency to educate and encourage all Americans to use these tools which we already have for better health.

I thank you, Senator Fowler, and the Committee, for this opportunity to discuss some of the health problems of women, and some of the CDC programs which address those health concerns. The programs I have described constitute a part of our vision for the women of America—a vision of women not simply living longer, but enjoying healthy, productive longer lives.

INACCURATE SCREENING TESTS

Senator FOWLER. Thank you, Ms. Bales, very, very much for a comprehensive statement.

I think we ought to go back to breast and cervical cancer, which Dr. Connell and Mrs. McIntyre discussed. We keep reading in the public reports, newspapers, and around, of increased instances of inaccurate screening tests, misread mammograms, outmoded diagnostic equipment. We have not talked about that this morning.

What can a woman do to ensure—Ms. Bales, we will start with you—what can a woman do to ensure that she is getting quality screening, and is the agency of CDC playing a role to ensure it? And I want Dr. Connell to comment on that.

Ms. BALES. A woman can do a fair amount, but I think the example in Wisconsin a few weeks ago that was widely publicized on breast screening quackery that was uncovered by a CDC-trained epidemiologist and the FDA is a good example of why it is really unrealistic to expect the individual woman to be held accountable for the quality of medical care she receives, but I am going for my biennial exam next month, and I know a lot about this issue, and I am going to be looking for quite a few things.

First, I expect my physician to do a complete clinical exam. He will refer me to a facility for mammography and I want to make sure that it is accredited by the American College of Radiology, and that is a voluntary accreditation, not a mandatory accreditation.

I would hope that my film, or I would expect and demand that my film be read by a board-certified radiologist, but not just a board-certified radiologist, one that has been trained to do mammography screening film reading, and not all of them are. That is not a requirement.

I would also if I found that place to go, and I think I have, I would try to go back to that same place every year because the chance of early detection of small changes would be enhanced by going back to a center that has your previous mammography screening films.

But I am lucky, I live in Atlanta and there are a lot of good choices for quality medical care here, and I know what to look for.

The new prevention program, the new breast and cervical cancer prevention program that will be funded in seven to nine States this year will greatly increase the chances that those quality services will be available statewide in the coming years.

Senator FOWLER. Do you want to comment on that, Dr. Connell?

Dr. CONNELL. I would like to say that I think these are very important issues, and having served on FDA committees for 21 years, which I think is a record in itself—I am still alive and I have had a normal mammogram recently—I would like to point out that I think the FDA and probably the current flap about underfunding and so forth is quite relevant. I think those are all important issues, and I think other arms of the government and professional societies are zeroing in on a lot of the problems that have been raised.

My concern is the 60 percent of women who have never even been screened, and here I think we have got to get into the educational issues. I think it is a mistake in many ways the way that health care is fragmented. You prevent osteoporosis in older women by teaching younger women to drink milk and teaching physicians that more than 15 to 20 percent of women who reach the menopause should be in replacement therapy, so it is a continuum of health care, and if you overfragment it it seems to me you do a disservice.

You learn healthy things early, you reinforce them in the middle years, and perhaps you will not have all of these problems that we have heard about more recently, so the continuity of care, I think, is important, and we are not doing an awfully good job with that, and I would respectfully wonder how much of it is due to the fact there is not really an awful lot of work going on looking at women.

Men are biologically inferior to women, I mean we have known this for a long, long time——

Senator FOWLER. But certainly necessary. [Laughter.]

Dr. CONNELL. This is brought out very, very early on. You know, there are 120 males conceived for every 100 women. By mid-years they sort of level out, and then the biologic inferiority of the men comes through very clearly in the older age group, and yet most of our cardiovascular data are on men, most of the cancer money goes to gentlemen's prostates rather than to women's breasts, so I think there are a lot of issues in this whole scenario that you could very profitably address, and we would certainly hope that you would.

Senator **Fowler**. I shall. [Laughter.]

I am sorry I left you, Ms. Bales. [Laughter.]

I want to ask you a question, whether or not the CDC has a role you can tell me, but I think a little broader than what we have talked specifically about this morning, but I would like to raise it with you.

As you know, through television and all the media, we get an avalanche of what we can describe this morning—and this is the mildest word that we can use—and that is unhealthy messages aimed at or about women.

We are told, especially women are told, it seems to me the message comes through that drug abuse and alcohol use are very romantic. We seem to condone violence by men on television, especially violence against women. We are certainly told women as you point out with statistics and the increase in breast cancer, we are certainly told through the advertising in the media that smoking is glamorous.

What can we do about that? Is there anything that the CDC can do specifically to counteract unhealthy messages that come through the media, especially with an eye on promoting and protecting the health of women?

Ms. **Bales**. Yes; there are things that CDC is doing now, and there are more opportunities to deliver a positive health message.

Dr. Roper in his tenure here has been emphasizing the area of health communications, which includes this whole area of delivering a positive health message to the American public and to targeted audiences.

This is not a small problem, it is an important problem. I think the numbers on young women smoking and women not quitting smoking are powerful indications of the impact of tobacco advertising and promotion.

I must make a comparison, however, when I begin to talk about some of the health messages that we are doing that the tobacco industry alone is spending $3 billion a year in promoting their product. CDC's budget to counteract those messages is about $1 million. It is going to be doubling next year with the President's new prevention budget, but it is a small message by comparison to these powerful images.

But we are doing something, we are doing something in tobacco, we are doing something in AIDS prevention, we are looking at a whole variety of areas, including violence and injuries, nutrition messages to counteract some of these images and the negative message that they portray.

In the area of tobacco where CDC has its longest standing mission and authority and resources, we run award-winning public information campaigns, and our emphases this past year, the year before, and in the coming year are on women, on teens, and on minorities to try to counteract some of these negative messages.

We had a very successful public information campaign last summer directed at teen women called "Fashion is in, Smoking is out" that aired on networks around the country, local TV stations, high school magazines, magazines that teens read, fashion magazines.

The Performance Edge is another public information campaign directed to high school kids. It is a very glamorous video spot coupled with a magazine and a teaching tool for high school coaches and health education teachers that is reaching thousands of schools around the country with a very positive image of the female and male athlete and the message to not use tobacco or alcohol.

The National AIDS Information and Education Program is a very sophisticated and nationwide as well as community-based information program directed at trying to change the behaviors that result in AIDS.

These are tremendous opportunities, and they are carried out both through these kind of public information campaigns which is a real opportunity for public health in the coming years, but also through professional education, working with the media, getting that headline story when there is an important prevention message to deliver.

Senator FOWLER. Ms. Bales, thank you very much.

Ladies and gentlemen, we could continue. This has been extremely informative to me, but I guess we have just about run out of time.

I want to thank this panel of witnesses for your time, your effort, and not only in your testimony but what you are doing, the work that you are doing represented by your testimony which is not only important work, it is vital work, and it is in the public interest, and those of us who serve in elective office are extremely grateful for that work and wish you Godspeed.

I have got a statement I will put in the record, and you do not need a summary from me, but I am going to take a little chance here, and with so many of the doctors and scientists, the people from the Centers for Disease Control here. First of all, let me thank the over 6,000 employees, not all of them in Atlanta, but throughout the country, for your work and for the same reasons that I just commended the panel.

But I think I would be remiss at least in my own mind if I did not issue what I hope is a slight challenge as I encourage you to continue with the work you are doing.

When I was running for the U.S. Senate in 1986 and going from county to county, these 159 counties you have heard referred to, it was absolutely amazing to me how many—and it was usually by women—how many questions without any prompting whatsoever were along the lines "Why cannot the government do more to ensure that the air we breathe and the water we drink and the food we eat are as free from contaminants as possible?" And all of a sudden it dawned on me that somewhere along the line over the last 3 or 4 years what had always been, and still is framed as quote-unquote environmental issues had been mystically transformed in the minds of ordinary citizens in our State from an environmental issue into an issue of health, and as all of you know who are health professionals in one sense of the word, in the best sense of the word, regardless of what kind of work you do, all of a sudden it dawned on me once something becomes a health issue in the mind of an individual or their family it does not go away. It has to be dealt with; there has to be a remedy, hopefully be a cure, or, in step with the whole emphasis of this hearing today, ways to prevent.

The good Lord did not design our bodies to accommodate chemicals. If you have a concentration of chemicals in your liver or your pancreas or any organ of the body you are going to have a very high risk of cancer, and if those of you at this agency can help us make the case that when we talk about environmental policy and environmental problems we are really talking about health problems that can be prevented if we have the right policies in what we put on our food and what we put in our air and our water, I have this suspicion that we will make extraordinary progress above and beyond what we are doing now.

Just to show you how far I am willing to go from preaching to meddling, with all these scientists here somebody one of these days will win a Nobel Prize by examining the incidence of cancer enhancements of chemicals on tobacco. This is not a refutation of any of your and our Nation's work in preventing smoking, but if you fire up a chemical you will get a carcinogenic reaction, and you still have people smoking in the Soviet Union and smoking in Japan who are over 100 years old with almost no incidence of lung cancer, and one of the reasons for that I assume, since I am not going to win the Nobel Prize, is they do not put any chemicals on their tobacco.

We have got to press on together, and I am extraordinarily grateful for your work on behalf of all of our citizens.

I will take a lot of what I have learned back to the Appropriations Committee as we deal with your budgets. I think you were almost polite in not going overboard, Dr. Roper, on the infrastructure problems, but I know about them and I want to see them addressed so that you can do your work and I am pleased to be at least one representative who is in the right place at the right time to carry this message and to try to help you.

PREPARED STATEMENT

Thank you, Dr. Roper, all of your staff for their extraordinary help to me and my staff in making this day possible, and I think we have all learned something that will make us better public citizens in preventing some of these problems that affect the health especially of our women and children.

[The statement follows:]

STATEMENT OF SENATOR WYCHE FOWLER, JR.

Thanks to all our witnesses for their time and for their valuable insights. I will carry your thoughts back with me to my colleagues on the Senate Appropriations Committee. Our thanks also go to Dr. Roper and the Centers for Disease Control staff for their cooperation and assistance in this hearing.

We have heard from two panels with a morning's worth of extraordinary testimony, some of it quite hopeful, some of it terribly disturbing. But we have only touched on the CDC's vast array of prevention programs.

We know prevention works; we've seen vivid proof of that today. It is there to be done. We simply have not done enough. We have to question whether we have allocated our resources wisely when we spend $647 billion on health care every year, and 97 percent of this goes for the treatment of medical problems. Many of these problems can be prevented or controlled before individuals are robbed of their health and well being and burdened with unmanageable costs.

The economic argument for prevention is powerful. We're spending 12 percent of our GNP on health care costs. Effective vaccination against polio saves us an estimated $1 billion per year in treatment costs avoided; the measles vaccine program saves us $500 million annually. At this hearing, we barely broached what could be accomplished.

Similarly, we have only scratched the surface of the health problems facing women and children. Right here in Georgia we rank fourth in the nation in infant mortality, with 12.6 infant deaths for every 1,000 births. We rank second in fetal deaths, 11.4 out of every thousand. That comes as little surprise when for the last 15 years, Georgia has ranked in the top five states for low birth-weight babies—a sure sign of inadequate care during pregnancy.

Among women in Georgia, there were 841 breast cancer deaths in 1986, 912 in 1988, and over 1,000 estimated for 1991. These deaths are largely preventable, yet their numbers are increasing.

Nationwide, an estimated 80,000 women of childbearing age are HIV-infected. That translates into 1,500 to 2,100 babies a year born with the AIDS virus. Taking care of each of these young victims costs us as much as $1,000 per day.

The CDC is our first line of defense against these critical health problems. And I can only applaud the dedication and achievements of the 6,000 men and women who make this agency work. Yet, I know we can do better.

Over the past decade, our nation has suffered immeasurably from the AIDS epidemic and several other public health threats. We in Washington have marshalled our resources to fight these critical emergencies, and the battles are still raging on. We've had to rely heavily on CDC's capabilities in disease surveillance and research. We've asked CDC to develop major new programs in disease prevention.

But during this period, the Agency has been weakened from within. Top scientists are leaving. Facilities have become obsolete. In real terms, funding for CDC's core programs actually declined by more than $150 million over the course of the eighties.

We simply cannot let this trend continue. This may only be one federal agency among many starved for more funding. But with all our efforts, as a nation, to educate our people, to house them and even to defend them, we cannot forget that health is our first priority.

Everything else we hope to accomplish—whether it's to improve performance in our schools or to compete in the global marketplace—is predicated on healthy citizens and affordable health care.

We cannot afford to forgo immunizations for healthy children. Women of childbearing age must have access to prenatal care, and must take the proper precautions to ensure they will deliver healthy babies. We need screening for breast and cervical cancer and other problems that can be cured if they are caught early.

I'd better stop before I get carried away with my own pontification. But I do want to say a word of thanks to the CDC professionals who have stuck with their task in difficult times.

Your work is so critical to so many Americans. There is nothing that touches the lives of families everywhere more closely than a child who is born healthy, or a mother who can be saved from cancer. We will try, in the future, to do better by all of you, and by all of them.

CONCLUSION OF HEARING

Senator Fowler. Thank you all very much for your attendance. The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 11:55 a.m., Monday, May 20, the hearing was concluded, and the subcommittee was recessed, to reconvene subject to the call of the Chair.]

Material Submitted Subsequent to Conclusion of Hearing

[CLERK'S NOTE.—The following statements and letters were received subsequent to the conclusion of the hearing, and will be submitted in the record at this point.]

STATEMENT OF FOUNDATION OF WESLEY HOMES, ATLANTA, GA

PREVENTION OF LOSS OF INDEPENDENCE AMONG FRAIL ELDERLY: IMPLICATIONS FOR ACUTE HOSPITAL CARE

The fastest growing segment of the U.S. population is that of individuals 85 years and older, two thirds of whom are women. One of the most important goals of health care for these women is to prevent their loss of independence, the major determinant of nursing home admission. To achieve this goal, acute hospital care must both effectively treat acute illness and maintain and restore functional independence.

The relationship between acute hospital care and loss of independence among frail elderly women is an important public health and public policy problem. Specifically, there is growing evidence that elderly patients lose functional independence in the course of acute hospitalization. At hospital discharge they are also on average more dependent than prior to hospital admission. A recent study of hospitalized patients in New York State demonstrated that the group of patients most subject to adverse events, are those over the age of 65 years.

A major mission of the Wesley Woods Geriatric Hospital is to provide "low tech" relatively non-invasive and non-intensive care oriented acute medical care to frail elders which is directed toward the restoration and maintenance of functional independence. A case example will illustrate several distinctive aspects of the care provided on our acute medical unit.

A 92 year old woman living independently in a senior community was admitted to the Wesley Woods Geriatric Hospital Medical Unit because of recurrent falling. Several days before admission, she had slipped and fallen once; because of pain, she subsequently decreased her food intake while continuing to take her medication for high blood pressure. She then fell several more times and was admitted to the hospital. Evaluation indicated that her blood pressure was too low when she stood up. She was treated for 2 days with intravenous fluids which restored her blood pressure to normal. Because of pain and weakness, however, she was unable to transfer out of bed. After 4 days of treatment for her pain and therapy directed at increasing her arm and leg strength, she was able to transfer independently and was discharged home. The time required to treat both her illness (low blood pressure) and restore her to independent function (transferring out of bed) was 6 days. The number of days the Medicare Prospective Payment System was willing to reimburse, based only on this patient's illness diagnosis, was 4.4 days. Thus, although our hospital treatment efficiently and effectively restored the patient to her former level of independence, the time required to achieve this goal resulted in a net revenue loss to the hospital.

To determine whether or not this was typical of our experience with the Wesley Woods Medical Unit, we conducted a review of 140 medical records which was a 10 percent random sample of all admissions to the medical unit since it opened in 1987. We set out to obtain information on the following questions: (1) Are we providing care to frail elders who are at risk of losing their independence? (2) Do these patients require a longer length of stay than is covered by the Medicare Prospective Payment System (which is based on illness alone but does not take into account treatment necessary to restore functional independence)?

Although the data obtained from such a medical record review cannot provide definitive answers to these questions, the result of this review suggests that the case outlined above is in many ways representative of our overall patient experience. Our findings can be summarized as follows:

(1) The average age of our patients is 76 with 30 percent being over age 85 years. Two thirds of our patients are women. Three quarters of our patients on admission have lost the ability to perform at least one major self care activity and more than half (56 percent) require help with 4 or 5 major self care activities. This is consistent with the hypothesis that we care for a select population of frail elders who are at risk of losing their independence.

(2) On average our patients remained in the hospital 3 days longer than the number of days reimbursed under the Medicare Prospective Payment System. The number of nonreimbursed hospital days seems to be increasing with time. During the first 2 years, patient stays exceeded the reimbursement length of stay by 1.6 days. During the most recent 2 years, the number of days exceeding reimbursement length of stay is 4.5 days. We think this is because the patients we care for are increasingly less independent. For example, the average number of self care activities with which patients needed assistance during the first 2 years was 3, while during the last 2 years patients required assistance on average with 4 self care activities. As demonstrated in our case example, this is consistent with the hypothesis that the excess number of hospital days our frail elders require is primarily related to their need to restore functional independence.

(3) Of patients admitted from home, approximately 75 percent are discharged home. It was not possible, from this retrospective chart review, to determine the change in independence from hospital admission to hospital discharge.

Problem

This data suggests: (1) We care for a group of frail elders who are at risk of losing their independence; and (2) that to treat these patients in a manner that takes into account both their acute illness and their need for functional independence requires a length of hospital stay which systematically exceeds that allowed by the Medicare Reimbursement System, which is based solely on the treatment of illness.

Proposed solution

It would appear that a prospective payment system is required which takes into account both disease diagnosis (DRG's) and level of functional dependence (RUGS). Such a prospective payment system, which would in effect be DRG/RUGS "hybrid", would take into account the additional hospital days required to return patients to their previous level of functional independence. In the long run, such a "hybrid" prospective payment system should save money for the following reasons:

(1) This type of non-invasive "low/tech" care is less costly than the usual invasive high/tech care delivered in acute care hospitals; (2) this type of specialized care, directed to the unique aspects of frail elders' illness and functional dependence, will likely lead to fewer adverse events during hospitalization; and (3) returning patients to their previous level of functional independence at hospital discharge decreases the likelihood that nursing home care will be required.

We suggest that a prospective payment system which adequately covers the cost of this type of specialized care would have a significant impact on the prevention of loss of independence among frail elderly women.

STATEMENT OF PLANNED PARENTHOOD OF THE ATLANTA AREA, ATLANTA, GA

Senator Fowler, thank you for the opportunity to present testimony. This information is provided to you on behalf of Planned Parenthood of the Atlanta Area and of East Central Georgia.

I have attached in a separate sheet, information from a 1990 study by the Alan Guttmacher Institute on cost effectiveness of government funded contraceptive services, showing that each dollar spent in family planning saves $4.40 in medical and welfare costs over the immediate two year period.

The provision of family planning services to all who need and want them is an essential link to improved maternal and infant health. In 1990, 227,000 Georgians utilized Title X family planning services in 231 local sites throughout the state of Georgia. Approximately 92 percent of the clients served have incomes less than 150 percent of poverty level and 34 percent are teenage women. For most low income women, this is the only health care they receive.

Georgia has the third highest teenage pregnancy rate in the nation for 15 to 19 year olds. Since pregnancy is the No. 1 cause of girls dropping out of school, it is not altogether surprising that only 61 percent of Georgia's children graduate from high school, or that one fourth of Georgia's families live in poverty.

The second enclosure is the analysis of "Teen Childbearing: Public Costs in Georgia, 1988," put together by the Cooperative Extension Service of the University of Georgia. This analysis focuses on the public costs of AFDC, medicaid, and food stamps for families with teen parents. For one year—1988—the cost for supporting families begun when mothers were teenagers was $232 million. Other costs incurred by many teen parents, such as special education or health care, are not included here. And, only 1 of every 3 teen mothers receives public assistance. If all births to teens were delayed until mothers were at least 20 years of age, 40 percent of these costs would be saved.

We have the ability to address these problems. Decatur's Oakhurst project and the DAISY project in Ware, Candler, Clinch, Coffee, Appling and Bulloch Counties link social services and comprehensive adolescent health services to the schools. More funding for this and similar programs is needed, including federal Medicaid dollars. DAISY is an extremely successful model of cooperation among the local health department, Family and Children's Services, Board of Education, and community. This model should be reproduced without delay.

In addition, we applaud our state Department of Human Resources' cooperative efforts with the Department of Medical Assistance to best utilize Federal Medicaid funds for an array of cost effective health services.

Public-private partnerships are also essential. Planned Parenthood, a nonprofit corporation, provides reproductive health care at clinics in downtown and South Atlanta, Cobb and Gwinnett Counties, Augusta, and Savannah. Downtown Atlanta serves 10,000 patients with 16,000 clinic visits per year. Over 90 percent are subsidized, 33 percent at no cost. For them, we prevented an estimated 4,400 unintended pregnancies in 1990 and provided cancer screening, diagnosis and treatment of sexually transmitted diseases. In fiscal year 1991, Planned Parenthood of Atlanta received $420,000 in public funds (57 percent State and 43 percent Federal Title X) and a $36,000 grant for HIV testing and counseling. We would like to meet the compelling need for Chlamydia testing at $14 per slide, since this often asymptomatic STD can cause infertility. We need a percentage increase in the grant because needs and costs are rising (e.g. Pap smears from $4 to $6 each).

Sterilization is the contraceptive choice of 24 percent of all couples. Planned Parenthood of East Central Georgia (Augusta) has a State grant to provide laparoscopic sterilization. In 1989–90, the clinic performed 231 tubal ligations and 29 vasectomies. 47 percent were eligible for financial assistance, 32 percent received full state funding. As of today, PPECG has a waiting list of 108 women and 39 men, because funds for the year have run out. Each tubal ligation is reimbursed at $400 but costs $423. Each vasectomy costs $313.70 but is reimbursed at only $150. Augusta seeks a contract increase to break even and to provide sterilization to the patients who are waiting.

We hope the Senate will exercise its leadership by placing more emphasis on these and related prevention programs. Thank you very much.

[LETTER FROM DR. JEAN RAWLINGS SUMNER]

SANDERSVILLE, GA, *May 23, 1991.*

Ms. JANET ABRAMS,
Legislative Assistant to Senator Wyche Fowler, Jr., Office of U.S. Senator Wyche Fowler, Jr., Committee on Appropriations, Washington, DC.

DEAR MS. ABRAMS: Thank you for your recent letter regarding the hearings at the Center for Disease Control. I have summarized my thoughts and will list them here.

(1) Care for indigent and uninsured individuals must be decentralized. But rather than pregnant individuals being transported to Augusta, the physician and student should be required to spend some time in each county on a monthly basis evaluating normal pregnancies. Of course any complicated pregnancy would be referred on to the Medical College. I think this would improve patient care dramatically, and I am certain that it would decrease costs.

(2) There are many Family Practice residencies in this state. These individuals practice and learn in academic settings in cities that is not akin to actual private practice. I think that each Family Practice resident should be required to spend time in counties where there is no physician. The county should be required to provide a facility for that physician and he should provide care for indigent patients as part of his training.

(3) Individuals who receive Medicare or Medicaid or Federally funded health insurance should not be allowed to self-refer themselves to sub-specialists. I do not think that you can control individuals who pay for these services independently from private funds, but having a gate-keeper of sort, such as the primary care physician would decrease costs and decrease unnecessary procedures. It would also improve the quality of care. Self-referral does not occur in countries such as England with the National Health Service. All individuals must see a generalist before they

are allowed to be referred to a sub-specialist unless there is an obvious overwhelming problem that requires a sub-specialist's immediate attention.

These three simple ideas I hope you will consider. I will be glad to elaborate on them if you are interested.

Thank you again for your recent letter and interest.

Sincerely,

JEAN R. SUMNER, M.D.

STATEMENT OF DR. MARILYNN R. WINSTON, ATLANTA AREA CHAPTER, ALZHEIMER'S ASSOCIATION

ELDER CARE: A WOMAN'S CONCERN

Today, a woman can expect to spend an average of 17 years caring for her children and an additional 18 years helping her aging parents or spouse. Currently, 90 percent of caregivers are women—more than half are wives and 40 percent are adult daughters and daughter-in-laws. The average female caregiver of an elderly family member is 54 years old—the age that most women hope to finally have some "free" time for themselves. Instead, she must face the stressful burden of providing elder care.

As more women join the labor force, they are presented with the task of balancing family, career and caring for an aging adult relative. Recent studies also indicate that employed caregivers are having to alter their work hours or take unpaid leave to meet the unrelenting demands of caregiving. Increasingly, many must give up work entirely because of the demands at home. And, if the aging adult relative has Alzheimer's Disease then the caregiver must juggle the responsibilities of job, children and the "36-hour day" demanded by the affected family member at home. Presently in Georgia, there are 84,000 Alzheimer's patients. The impact of this disease is devastating, not only on the patient but also on the family. Caring for an Alzheimer's victim is both a physically and emotionally unrelenting responsibility. Although it costs a family an average of $18,000 a year to care for their family member at home, it could cost taxpayers $54 billion each year to replace the full-time care provided by relatives of the 1.8 million adults with severe Alzheimer Disease.

Multiple role strain is a frequently used term in the media. It occurs when adult children attempt to meet all their responsibilities as a parent, child, spouse and competent member of the work force. Multiple role strain produces physical exhaustion, chronic headaches, stomach problems and emotional fatigue.

The Atlanta Area Chapter Alzheimer's Association is here to "Stand By" both the patient and family caregiver. The Chapter provides respite—relief from the constant responsibilities of caregiving—with our specialized Adult Day Center (open Monday-Friday, 7:30 a.m. to 5:30 p.m.) and an In-Home Respite Registry (providing trained respite workers in the home). There are 26 support groups throughout Atlanta which meet monthly. These can be an outlet for the caregiver to express her frustrations or share helpful suggestions and techniques with other individuals who know what she is going through. The Chapter "Helpline" is available for counseling, information and referrals. Through these services, the Chapter is able to provide emotional support and practical assistance.

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